SCOTTISH COVID-19 INQUIRY

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Written Statement of Dr Iain Kennedy

on behalf of the British Medical Association (BMA) Scotland

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I, Dr Iain Kennedy, will say as follows:

1. I am the Chair of the BMA's Scottish Council and have held this role since August 2022. Prior to that I sat on the BMA's Scottish Council and GP committee and did so throughout the pandemic, although I was not involved in day-to-day decision making for BMA Scotland relating to Covid-19. I work as a GP in Inverness.

2. In providing this statement, I have sought input and assistance from colleagues who chair Branch of Practice Committees in Scotland, the Deputy Chairs of Scottish Council, those who held elected posts between 2020 and 2022, and relevant policy and communications teams. The information contained within this statement is true to the best of my knowledge and belief.

3. This statement is designed to provide a high-level overview of the impact of the Covid-19 pandemic on doctors and healthcare services in Scotland. It focuses on the period outlined by the Scottish Covid-19 Inquiry (the Inquiry), namely 1 January 2020 to 31 December 2022, although it will be important for the Inquiry to take into consideration that many of these impacts are still ongoing. The statement is structured as follows:

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A. Overview of the British Medical Association in Scotland

4. The BMA is a professional body and trade union for doctors and medical students in the UK, representing the views of doctors working in all branches of medical practice and specialties. Through the experience and insight of its membership, the BMA has a wealth of information and evidence about how the pandemic impacted on doctors and wider healthcare systems.

5. The overwhelming priority of the BMA's members is to ensure that they provide the best possible care and treatment for their patients. During the pandemic, doctors and other healthcare staff worked tirelessly to safeguard the nation's health and care for those in need, often at great personal cost to their physical and mental health.

About the BMA – role, function and aims

6. The BMA is a leading voice advocating for outstanding healthcare and a healthy population, providing members with individual services and support throughout their lives.

7. As a trade union, the BMA is formally recognised for collective bargaining purposes at a UK, devolved nation and local level. It represents, supports and negotiates on behalf of all doctors and medical students in the UK and currently has a membership of more than 191,000 (approximately half of practising doctors) in the UK and more than 17,000 in Scotland.

8. Members of the BMA come from all branches of medical practice and specialities, for example GPs, consultants, public health, occupational medicine, medical academics, students and doctors in training.

9. The BMA's mission statement is 'We look after doctors so they can look after you'. Its vision is 'a profession of valued doctors delivering the highest quality health services, where all doctors:

    a. Have strong representation and expert guidance whenever they need it.

    b. Have their individual needs responded to, through career-long support and professional development.

    c. Are championed by the BMA and their voices are sought, heard and acted upon.

    d. Can connect with each other as a professional community.

    e. Can influence the advancement of health and the profession.'

10. Staff and elected members work to support, protect and represent BMA members across all four UK nations. This includes:

   a. Negotiating on pay, terms and conditions at a UK, devolved nation and local level, and supporting the safeguarding of health, safety and wellbeing at work.

   b. Providing individualised employment support and advice for members, including through the BMA's First Point of Contact service.

   c. Providing wellbeing support services, with a free confidential counselling line and peer support service available to all doctors and medical students.

   d. Providing other services for members, including advice related to immigration, ethics, equality and diversity, and specialist HR and employment law advice for GP partners.

   e. Ensuring doctors' voices are heard by policymakers across the UK's governments and healthcare systems. To do this the BMA conducts research, produces policy recommendations, runs campaigns and makes representations to governments and decision makers. The BMA also works with a range of European partners and makes representations at a global level as part of the World Medical Association.

About BMA Scotland – structure and organisation within Scotland

11. The BMA in Scotland provides representation for doctors in Scotland across branches of medical practice and specialities, including for example GPs, consultants, public health, speciality doctors, students and doctors in training. Working on behalf of these doctors, BMA Scotland provides individual representation and advice, national negotiations, local engagement and support, and develops and delivers policy, communications and public affairs work specific to Scottish circumstances.

12. The BMA's Scottish Council reports to the BMA's UK Council and considers all matters of specific relevance to the medical profession and healthcare in Scotland, determining policy and action where the application is exclusive to Scotland. A significant proportion of members of Scottish Council are directly elected and broadly reflect the geographical and branch of practice distribution of the profession in Scotland. BMA Scotland has its own elected branch of practice structure and executive-led teams that independently formulate and implement policies relevant and applicable to the Scottish context (having regard to the policies and position of the wider BMA). Branch of practice committees consider and act on matters affecting their branch of practice in Scotland and have delegated authority to negotiate terms and conditions of service.

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13. The Scottish Council has 35 voting seats, each assigned to a particular grade and/or region of Scotland: consultants, GPs, Specialty and Associate Specialist doctors, junior doctors, students, medical academics, retired members, and other branches of practice not represented, such as those working in the civil service, armed forces, or occupational health. The voting members are elected for a three-year term of office. The current term of office runs from 2023 to 2026.

14. In addition to Scottish Council, BMA Scotland has the following committees:

    a. Scottish Consultants Committee

    b. Scottish General Practitioners Committee

    c. Scottish Staff Grades and Associate Specialists Committee

    d. Scottish Junior Doctors Committee

    e. Scottish Medical Students Committee

    f. Scottish Local Negotiating Committees Forum

    g. Scottish Race Equality Forum

15. BMA Scotland aims to support its members to provide the best possible care for their patients. During the period outlined by the Inquiry BMA Scotland sought to understand the issues impacting doctors across Scotland and to feed this information into decisions made by the Scottish Government. The available staffing capacity of BMA Scotland, and the focus on issues that directly affected their members, meant that BMA Scotland did not take a position on wider policy decisions made in Scotland in relation to the response to the Covid-19 pandemic (for example, in relation to all non-pharmaceutical interventions (NPIs) applied). This was especially the case where other parts of the Association were better placed to do so, and certainly so in areas that were not devolved.

16. The extent to which BMA Scotland attempted to address specific issues that arose in Scotland was determined by the priorities of its elected committees and Scottish Council, acting on behalf of the wider medical profession in Scotland.

B. Key issues and impacts for doctors

Overview of the impact on doctors

17. Being exposed to a potentially deadly virus while treating patients without always having appropriate personal protective equipment (PPE), no or inadequate risk assessments and initially limited Covid-19 testing has had a profound impact on the mental and

physical health of the medical workforce. Many caught Covid-19 at work and over fifty doctors across the UK died from the virus[1]. In Scotland, an FOI request indicated that as of November 2021 twenty-six healthcare workers had died from Covid-19[2].

18. Experiences of burnout, trauma, moral distress, isolation and poor psychological safety were, and continue to be, commonplace. A significant number of doctors and healthcare workers acquired Long Covid and are still limited in their ability to work or train. To this day, doctors and healthcare workers are still not guaranteed to receive the right level of protection as a result of Scotland's Infection Prevention and Control (IPC) guidance. IPC guidance in Scotland failed, and continues to fail, to properly recognise that Covid-19 spreads via the air, and instead places responsibility on individual healthcare workers to raise concerns about PPE and ensure they have the necessary fit testing (see paragraphs 53 to 58 for more information).

19. The impacts of the pandemic were not felt equally, for healthcare staff or patients. UK-wide data from BMA surveys indicate that ethnic minority doctors more commonly had to work without PPE, felt worried or fearful about speaking out, and felt risk assessments had been ineffective. The gender bias within PPE design meant that female doctors often struggled with poorly fitting PPE that left them exposed. Doctors with a disability or long-term health condition felt less protected than their colleagues, were more likely to experience worsening mental health and some experienced challenges with remote working. There was widespread disruption to training as a result of redeployment and a reduction in non-Covid care which had a particular impact on medical students and junior doctors.

20. In terms of patient care, many doctors told the BMA in these UK-wide surveys that they experienced moral distress in relation to their own or colleagues' ability to provide care during the pandemic. When explored further in a later UK-wide moral distress survey, the reasons for moral distress included insufficient staffing to suitably treat all patients, individual mental fatigue, a lack of time to provide emotional support to patients and an inability to provide timely treatment.

21. Governments in the UK, and their associated bodies, did not always provide clear, adequate and consistent guidance on a number of issues affecting patients, healthcare workers and the delivery of healthcare during the pandemic. This includes guidance

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[1] The BMA collected the names of doctors in the UK who died from Covid-19 while working in the health service during the pandemic. Through this, the BMA identified 53 doctors. However, this figure is not exhaustive, and there may be other doctors who have died from Covid-19. These doctors were not necessarily members of the BMA. Available at: https://www.bmj.com/covid-memorial

[2] Available at: https://www.gov.scot/publications/foi-202100240573/

related to risk assessments; IPC; decision-making, triage and resource allocation should resources become overwhelmed; profession-specific shielding advice and advice on supporting healthcare staff who were shielding to return to work. As a result, the BMA published its own guidance on many of these topics (see paragraph 157). Even when government guidance was issued, it was not always well communicated or implemented.

There was a significant impact on doctors' mental health

22. The BMA's UK-wide Call for Evidence survey[3] showed that many doctors suffered from anxiety and/or depression during the pandemic, and in some cases, this was exacerbated by worries over making mistakes when redeployed and being held liable for decisions made in extremely difficult circumstances, often in new environments and with limited resources.

23. Delivering care amid persistent staff shortages (see paragraphs 117 – 125) fosters an environment of chronic stress, normalising excessive workloads by continuously requiring overstretched staff to fill gaps to keep services running. Alongside this, many traditional avenues for doctors and other healthcare staff to get a break were removed during the pandemic. For example, in many places break rooms were closed due to IPC measures and historic staffing shortages meant that staff had limited opportunities to take leave.

24. In the Call for Evidence survey, a SAS (Staff, Associate Specialist and Speciality) doctor in Scotland described their experience as: *"so much anxiety at seeing ill patients and worrying about bringing it home to my family. Constant threat. Would I pay the price for helping? Overwhelming, anxiety and palpitations [for] 21 months. Sleep disturbance, frustration, guilt"*. Other respondents in Scotland describe their experience as *"horrific", "devastating", "overwhelming", "incredibly scary"* with *"continuous worry"*.

25. Calls to the BMA's UK-wide wellbeing services regarding work-related demands increased by 150% between 2019 and 2021, and calls regarding work-related stress increased by 63%. In this context it is not surprising that, at the end of April 2020, 25% of Scotland respondents to a BMA survey said their mental health[4] was worse than before the pandemic. The impact on staff mental health worsened as the pandemic

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[3] The BMA conducted a wide-ranging Call for Evidence survey between 10 November – 17 December 2021 which encouraged members to pause and reflect on their experience during the pandemic and provided them with an opportunity to describe the impact of Covid-19 in their own words. A copy of the survey questions is exhibited as Exhibit IK/1. For more information see paragraph 154.

[4] This includes depression, anxiety, stress, burnout, emotional distress or other mental health condition relating to or made worse by work. BMA Covid-19 Tracker survey (UK-wide), 30 April 2020. This question was answered by 1,171 respondents from Scotland.

progressed. In April 2021, one year into the pandemic, almost half of Scotland respondents to a BMA survey said their mental health suffered because of their work or study[5]. This ongoing impact on their mental health was described by a GP in Scotland responding to the Call for Evidence who said: *"I have never felt more stressed at work before. I was drowning and fire-fighting at the same time! Going home and repeating… like ground hog day."*

26. There were also inequalities in the impact of the pandemic on the mental health of medical professionals. For example, at a UK-wide level a BMA survey in April 2021 showed that a decline in good mental health was more common in female respondents (40%), relative to male respondents (34%). Worse mental health was also reported as more common in respondents with a disability or long-term condition (49%) than those without (35%)[6].

27. Moreover a UK-wide BMA survey in 2021 on moral distress[7] and moral injury[8] found highly alarming levels of distress. Among respondents who only saw Covid-19 patients, 97% stated they had experienced moral distress in relation to their own ability to provide care during the pandemic, and 88% had experienced this in relation to a colleague's ability to provide care. This was noted by a respondent in the Call for Evidence who described: *"feeling that the service my service was providing was not good enough or not enough, and the moral injury of feeling no matter how hard I worked that the system was still failing the families I serve."*

28. The causes of moral distress in medical staff are varied but they are often consistent across countries. Doctors can experience moral distress due to a range of factors, including lack of agency to make the best decisions for patients and insufficient resources or non-existent resources to provide care to suitable professional standards.

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[5] BMA Covid-19 Tracker survey (UK-wide), 19 April 2021. This question was answered by 615 respondents from Scotland.

[6] BMA Covid-19 Tracker survey (UK-wide), 19 April 2021. This question was answered by 4,992 respondents who provided information about their gender and 4,946 respondents who provided information about their disability or long-term health condition (LTC). Gender and disability/LTC breakdowns within respondents from Scotland are not available.

[7] Moral distress refers to the psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action. Even without an understanding of the morally correct action, moral distress can arise from the sense of a moral transgression. More simply, it is the feeling of unease stemming from situations where institutionally required behaviour does not align with moral principles. This can be as a result of a lack of power or agency, or structural limitations, such as insufficient staff, resources, training or time. The individual suffering from moral distress need not be the one who has acted or failed to act; moral distress can be caused by witnessing moral transgressions by others.

[8] Moral injury can arise where sustained moral distress leads to impaired function or longer-term psychological harm. Moral injury can produce profound guilt and shame, and in some cases also a sense of betrayal, anger and profound 'moral disorientation'. It has also been linked to severe mental health issues.

29. BMA Scotland regularly raised concerns about the pandemic's impact on the wellbeing of doctors, for example within meetings of the Management Steering Group (see paragraph 164c), and in meetings with the Scottish Government and the Cabinet Secretary for Health.

30. One key way BMA Scotland sought to help ease the pressure on doctor wellbeing during the pandemic was to work with other organisations and partners including the General Medical Council (GMC), NHS Education for Scotland (NES) and the Academy of Medical Royal Colleges and Faculties in Scotland (Scottish Academy) to ensure that medical appraisal was both less onerous and more focused on wellbeing. BMA Scotland worked with NES on an addition of key text to the Scottish Online Appraisal Resource (SOAR) which was clear that: *"Appraisals for this year will focus on well-being as many doctors will have found the last few months challenging and will have experienced difficulty in collecting evidence for the various appraisal domains."* This was accompanied by a joint statement to further emphasise this[9].

31. BMA Scotland published several reports and briefings highlighting the need for better support for doctor wellbeing, including a briefing for a Scottish Government debate on healthcare system recovery in June 2021[10] and the report *'Supporting junior doctor wellbeing – now, and for the future'* in October 2021[11]. BMA Scotland also flagged concerns around the wellbeing and mental health of doctors in evidence submitted to the Health and Sport Committee inquiry on resilience and emergency planning in June 2020 (Exhibit IK/2). Recommendations in this evidence submission included access to rest facilities, provision of hot food, free parking, dedicated time for continued professional development, and confidential access to services to help with mental health. BMA Scotland also regularly referenced the need for a focus on, and support for doctor wellbeing in blogs[12] and media communication throughout.

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[9] BMA Scotland: Joint statement about wellbeing and medical appraisals in Scotland' (01 October 2020). Available at: https://www.bma.org.uk/news-and-opinion/joint-statement-about-wellbeing-and-medical-appraisals-in-scotland

[10] BMA Scotland brief: 'Scottish Government debate: health recovery' (June 2021). Available at: https://www.bma.org.uk/media/4748/bma-scotland-briefing-on-health-recovery-jun2021.pdf

[11] BMA Scotland report: 'BMA Scotland supporting junior doctor wellbeing – now and for the future' (October 2021). Available at: https://www.bma.org.uk/media/4670/bma-supporting-junior-doctor-wellbeing_final-publication-october-2021.pdf

[12] See for example the BMA Scotland blog posts: 'No room for complacency – we must keep NHS staff safe' (10 July 2020), available at: https://bmascotland.home.blog/2020/07/10/no-room-for-complacency-we-must-keep-nhs-staff-safe/ or 'GP update – vaccination and wellbeing' (08 January 2021), available at: https://bmascotland.home.blog/2021/01/08/gp-update-vaccination-and-wellbeing/

32. During the discourse around 'restarting' the NHS in June 2020, BMA Scotland put forward 5 key asks[13] – one of which was that comprehensive measures must be taken to safeguard staff wellbeing. This included that *"there must be specific and targeted support for those in the workforce who have suffered due to the work in the highly stressful Covid-19 environments. This must be long term, as the effects will be long lasting."*

33. At a UK-wide level the BMA called for additional support for staff mental health in reports including: *'In the balance: Ten principles for how the NHS should approach restarting non-Covid care'* (May 2020)[14]; *'The mental health and wellbeing of the medical workforce – now and beyond Covid-19'* (May 2020)[15]; *'Rest, Recover, Restore: Getting UK health services back on track'* (March 2021)[16] and *'Weathering the Storm: Vital actions to minimise pressure on UK health services this winter'* (November 2021)[17].

The impact on doctors' physical health was profound and continues to this day

34. In addition to the mental health impacts of the pandemic that staff experienced, the pandemic also had a significant impact on staff physical health, with many getting infected with the virus, a significant number developing Long Covid and some sadly dying. Generally speaking, doctors, as well as other healthcare workers, experienced higher levels of infection compared to the general population[18]. The physical impact was described by a GP in Scotland who told the BMA: *"I caught Covid in December 2020 and have not been able to regain my physical strength. I continue to suffer from anosmia and breathlessness. On reading a BBC news piece, I saw a picture of a paramedic I had worked with who had died from Covid and could not stop crying for a day."*

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[13] BMA Scotland blog post: 'Our 5 key asks for restarting the NHS in Scotland' (02 June 2020), available at: https://bmascotland.home.blog/2020/06/02/our-5-key-asks-for-restarting-the-nhs-in-scotland/

[14] BMA report: 'In the balance: Ten principles for how the NHS should approach restarting non-Covid care' (May2020). Available at: https://www.bma.org.uk/media/2487/ten-principles.pdf

[15] BMA report: 'The mental health and wellbeing of the medical workforce – now and beyond Covid-19' (May 2020). Available at: https://www.bma.org.uk/media/2475/bma-covid-19-and-nhs-staff-mental-health-wellbeing-report-may-2020.pdf

[16] BMA report: 'Rest, recover, restore: Getting UK health services back on track' (March 2021). Available at: https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf

[17] BMA report: 'Weathering the storm: vital actions to minimise pressure on UK health services this winter' (November 2021). Available at: https://www.bma.org.uk/media/4834/bma-weathering-the-storm-report-nov21.pdf

[18] Nguyen et al. (2020) 'Risk of COVID-19 among front-line health-care workers and the general community: a prospective cohort study', The Lancet Public Health. Available at: https://doi.org/10.1016/S2468-2667(20)30164-X

35. The BMA included questions related to Covid-19 infection in some of its Covid Tracker surveys[19] and this information was self-reported by those who chose to respond to each survey. In a BMA survey in April 2021, 13% of respondents from Scotland said that they had contracted Covid-19[20] (Exhibit IK/3).

36. Alongside calling for greater support for staff mental health as outlined earlier in this statement, the BMA was also vocal about the need to support staff physical health. Support and protection for physical health is essential in its own right, but is also crucial to improving and protecting mental health (for example, fear of exposure to the virus due to inadequate or unavailable PPE had a negative impact on mental health).

37. BMA Scotland raised these concerns, for example within meetings of the Health Workforce Senior Leadership Group and Management Steering Group (see paragraph 164), in meetings with the Scottish Government and Cabinet Secretary for Health, and in email communications.

38. At a UK-wide level the BMA called for additional support for staff physical health in reports including: *'In the balance: Ten principles for how the NHS should approach restarting non-Covid care'* (May 2020)[21]; *'Rest, Recover, Restore: Getting UK health services back on track'* (March 2021)[22] and *'Weathering the Storm: Vital actions to minimise pressure on UK health services this winter'* (November 2021)[23].

39. The issues raised by BMA Scotland in relation to staff physical health include:

    a. The lack of access to adequate, well-fitting PPE that provided protection from airborne transmission (see paragraphs 53 – 65).

    b. The need for additional support for employers to undertake and implement risk assessments that would take into account not only age, but also other factors such as ethnicity, sex and comorbidities (see paragraphs 70 – 77).

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[19] The BMA undertook regular 'Covid Tracker' research surveys with its members throughout he pandemic to help understand the different experiences of doctors working on the frontline of Covid. Eight Covid Tracker surveys were sent to BMA members in Scotland between 06 April 2020 and 19 April 2021. For more information see paragraph 150.

[20] BMA Covid Tracker survey (UK-wide), 19 April 2021. This question was answered by 616 respondents from Scotland.

[21] BMA report: 'In the balance: Ten principles for how the NHS should approach restarting non-Covid care' (May2020). Available at: https://www.bma.org.uk/media/2487/ten-principles.pdf

[22] BMA report: 'Rest, recover, restore: Getting UK health services back on track' (March 2021). Available at: https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf

[23] BMA report: 'Weathering the storm: vital actions to minimise pressure on UK health services this winter' (November 2021). Available at: https://www.bma.org.uk/media/4834/bma-weathering-the-storm-report-nov21.pdf

c. Shortages of tests for staff and patients, particularly early in the pandemic (see paragraphs 78 - 82).

d. Limited access to occupational health services due to the rapid increase in demand and the lasting impact of pre-pandemic under-resourcing (see paragraph 74).

e. The impact of severe staffing shortages on staff wellbeing (see paragraphs 117 - 125).

f. Access to vaccinations, including member concerns with changes made to the dosing interval between the first and second dose of the Pfizer vaccine (see paragraphs 86 - 87).

40. The BMA also lobbied strongly for the provision of death in service benefits for all doctors and medical students risking their lives in the UK's health services.

a. BMA Scotland raised this in meetings and emails with the Health Workforce directorate during March and April 2020. The BMA was pleased when the UK Government eventually announced a new life assurance scheme on 27 April 2020 and made funding available to the devolved administrations to establish such schemes. The scheme in Scotland was announced on 29 April 2020 and was open to all frontline NHS and social care staff (including students and returning doctors who had previously retired) on their death from Covid-19 if they had contracted the virus in the course of their duties. This announcement gave staff putting their lives on the line at least some assurance in case they died while treating others.

b. The scheme in Scotland covered deaths occurring up until 30 June 2022 and included deaths where Covid-19 was 'a factor' on the death certificate or the death was 'at least partially attributable' to Covid-19. This scheme was more comprehensive than the schemes in England, Wales and Northern Ireland which required Covid-19 to be 'wholly or mainly' the cause of death.

c. BMA Scotland worked closely with the Scottish Government on delivering this scheme – and was grateful for the positive approach adopted. On publication of the scheme, the Deputy Chair of BMA Scotland's Consultant Committee wrote[24]: *"Our key ask was always that those individuals who were not fully covered (or covered at reduced levels) due to either being out of the scheme, having only*

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[24] BMA Scotland blog post: 'Update on death in service' (13 May 2020), available at: https://bmascotland.home.blog/2020/05/13/update-on-death-in-service/

recently joined, working on the staff bank or as locums, or not in the scheme at all were covered at the same level as those active members of the scheme. We were not seeking any additional payments, just fair treatment for all. There were certain groups we were worried would be left uncovered – in particular GP locums, bank staff and those that had been forced out of the scheme due to the taxation issues that we've previously raised. These are obviously stressful times for many doctors, and this was a further concern which would have just added to the level of worry. I am really pleased to say that thanks to this Scottish Government scheme, all of these groups are now covered."

Long Covid

41. A significant number of doctors who were infected with Covid-19 during the pandemic developed Long Covid. The prevalence of Long Covid – a multi-system condition defined as signs and symptoms which continue or develop after acute Covid-19 infection, continue for more than 4 weeks, and are not explained by an alternative diagnosis – is around 50% higher in those working in healthcare than in the general UK population[25].

42. Responses to the Call for Evidence survey had already begun to paint a devastating picture of Long Covid among a significant number of doctors who had worked in the pandemic. A Junior Doctor in Scotland, for example, said: *"I have developed Long Covid as a result of occupational exposure to Covid. This has completely destroyed my quality of life - causing unbelievable debilitating fatigue, pain, autonomic nervous system dysfunction, and cognitive/memory symptoms. I have gone from being completely independent and high functioning, to dependent…I have no idea what my future holds, if I'll be able to have a career, what quality of life I may be able to have."* Another Junior Doctor in Scotland said: *"I caught covid in March 2020 from a colleague at work. I have been mostly bedbound since. My life as I knew it had ended. These are supposed to be the best years of my life but I'm spending them alone, in bed, feeling like I'm dying almost all the time."*

43. To address the lack of systematic information on the long-term effects of Covid-19 among doctors specifically, the BMA undertook the first in-depth survey of doctors experiencing post-acute health complications of Covid-19 (the Long Covid survey). More

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[25] Office for National Statistics (ONS). Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK. 30 March 2023. Available from:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/alld atarelatingtoprevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk

than 600 doctors across the UK who self-identified as suffering the long-term effects of Covid-19 beyond the acute infection responded to the online survey. Many of the BMA's research findings have been published in the report *Over-exposed and under-protected: the long-term impact of Covid-19 on doctors* (July 2023)[26]. The findings have also since been published as an academic paper in the journal Occupational Medicine[27].

44. In the Long Covid survey, doctors reported a wide range of continuing symptoms and conditions including, but not limited to, fatigue, memory loss and other cognitive impairments, and autonomic nervous system dysfunction, such as heart rhythm disturbances or postural hypotension. At a UK-level[28], around 60% of doctors who responded to the survey reported that post-acute Covid-19 ill health impacted their ability to carry out day-to-day activities on a regular basis, while only 6% said their symptoms did not impact their day-to-day life. Post-acute Covid-19 complications have been profoundly injurious with around one fifth (18%) of respondents to the survey left unable to work or train because of their condition. Around one in three (31%) respondents said they were working or training full-time, compared to more than half (57%) before acquiring Covid-19. Nearly half (48%) said they had experienced loss of earnings because of post-acute Covid-19. For some this loss has been total, and earnings loss has impacted doctors from a range of professional backgrounds and career stages.

45. For most of the UK, including Scotland, the loss of job and income security for doctors with significant ill health has been greatly exacerbated by the removal of the NHS Covid Special Leave scheme in 2022. This change of policy brought an end to full sick pay for Covid-related illness for NHS employees in Scotland from 01 September 2022. It has precipitated an unjust situation where some doctors are not well enough to work as they did previously, either part of the time or at all. This happened despite strong lobbying by BMA Scotland (as well as other unions) to continue the scheme.

46. The BMA published a report, *Addressing the health challenge of Long Covid*, in August 2022[29] which examined the impact of Long Covid on the general population, as well as examining issues specific to doctors and other healthcare workers. The report included

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[26] BMA report: 'Over-exposed and under-protected: the long-term impact of Covid-19 on doctors' (July 2023). Available at: https://www.bma.org.uk/media/7318/bma-long-covid-report040723.pdf

[27] Bland et al (2023). Post-acute COVID-19 complications in UK doctors: results of a cross-sectional survey, Occupational Medicine. Available at: https://academic.oup.com/occmed/advance-article-abstract/doi/10.1093/occmed/kqad120/7468904

[28] Responses from Scotland showed similar impacts to those reported at a UK-wide level, however the sample size was smaller and it is therefore not possible to report the data separately.

[29] BMA report: 'Addressing the health challenge of Long Covid' (August 2022). Available at: https://www.bma.org.uk/media/6051/20220333-addressing-the-health-challenge-of-long-covid-final.pdf

a number of BMA's calls to government to support healthcare workers with Long Covid, including: recognition of Long Covid as an occupational disease for healthcare workers; immediate provision of financial support for those unable to work; better treatment support with thorough and effective investigations of symptoms; and better support for staff returning to work including access to phased returns and occupational health support. At a UK-wide level around three in 10 (27%) doctors who responded to the BMA's Long Covid survey reported that support and adjustments (such as phased returns and changes in shift patterns) had not been provided to help them return to work. To improve this, a better resourced and therefore more effective occupational health service is needed. The BMA has called upon health education bodies across the UK, for example within the *'Over-exposed and under-protected'* report noted earlier[30], to fund increased occupational medicine training posts to meet demand in the workforce and stated that health service employers must prioritise timely access to occupational health services and assessments for staff with post-acute Covid.

Impacts were not felt equally

47. The pandemic had a large disproportionate impact on those from ethnic minority backgrounds, who were more likely to become severely ill from the virus or die from it.

    a. UK-wide analysis by the Health Service Journal[31] found that 94% of doctors who died with Covid up to April 2020 were from ethnic minority backgrounds. The same analysis found that, among the wider healthcare workforce, 63% of deaths from Covid-19 were amongst those from an ethnic minority background. BMA Scotland is not aware of any Scotland-specific data on this.

    b. The BMA was one of the first organisations to spot the disproportionate impact on people from ethnic minority backgrounds, both those working in healthcare roles and the wider public, and was raising concerns from 09 April 2020, calling at a UK-level for an investigation into the issue.

    c. With large numbers of medical staff redeployed at the start of the pandemic, many staff were redeployed to other – even higher risk – areas to help the pandemic effort. UK-wide data from BMA surveys found that doctors from ethnic minority backgrounds often reported feeling more exposed in the

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[30] BMA report: 'Over-exposed and under-protected: the long-term impact of Covid-19 on doctors' (July 2023). Available at: https://www.bma.org.uk/media/7318/bma-long-covid-report040723.pdf

[31] Health Service Journal (22 April 2020). 'Exclusive: deaths of NHS staff from Covid-19 analysed'. Available at: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article

workplace, reporting ineffective risk assessments[32], less access to PPE (including respiratory protective equipment (RPE))[33] and feeling pressured to work without adequate protection compared to their White counterparts[34] – while at the same time feeling less able to raise concerns[35]. These issues are outlined in more detail in paragraphs 59 - 77.

   d. These impacts need to be considered in the context of structural inequalities and institutional racism in the UK, including in health services.

48. The pandemic had a significant impact on the physical and mental wellbeing of International Medical Graduates (IMGs) working in the UK, as well as international students studying here.

   a. For example, being unable to visit families abroad meant a usual source of comfort was taken away for many. Qualitative data from the BMA's Call for Evidence survey at a UK-level showed that an acute sense of isolation was felt among IMGs and international students.

   b. Many IMGs are also from ethnic minority backgrounds and therefore experienced the same disproportionate impact as other ethnic minority doctors.

   c. For IMGs who fell ill during the pandemic, there was a high degree of uncertainty about their future which impacted their mental wellbeing. This included uncertainty about the continuation of their employment and thus their right to remain in the UK, as well as what would happen to their family and dependants should they die. At a UK level the BMA successfully lobbied the Home Office to give indefinite leave to remain to the dependants of international doctors who died while working in the NHS during the Covid-19 pandemic.

49. Changes to how care was delivered impacted disabled doctors and those with long-term health conditions.

   a. Shifts to remote working, while of benefit to some, also introduced new issues for some groups of disabled doctors. For example, there were reports of

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[32] BMA Call for Evidence survey (UK-wide), 17 December 2021. Within respondents in Scotland, a breakdown by ethnicity is not available.

[33] BMA Covid Tracker survey (UK-wide), 30 April 2020. Within respondents in Scotland, a breakdown by ethnicity is not available.

[34] BMA Covid Tracker survey (UK-wide), 30 April 2020. Within respondents in Scotland, a breakdown by ethnicity is not available.

[35] BMA Covid Tracker survey (UK-wide), 14 May 2020. Within respondents in Scotland, a breakdown by ethnicity is not available.

equipment supplied for remote working not having the necessary adaptations for some disabled people.

b. Doctors with a disability or long-term health condition also more commonly reported poor mental health in BMA surveys, as outlined in paragraph 26.

c. The experiences of these doctors must be recognised and gaps in occupational health provision tackled as a priority. The pandemic necessitated the implementation of wide-ranging changes to working practices, often at considerable speed, but these happened without adequate assessment of the impact of these changes on disabled staff or those with long-term health conditions.

50. Doctors who were clinically extremely vulnerable (CEV) faced challenges at work.

a. Some doctors told us their CEV status was not taken into account at their place of work and some felt pressured to come into work, despite shielding. For example, in the Call for Evidence survey a GP from Scotland wrote: *"I was a locum at the time. I had no risk assessment and was ordered to go and work in a Covid hub despite being sent a shielding letter".*

b. Early in the pandemic, the BMA identified the need to provide specific guidance for doctors who were shielding, as well as doctors not on the shielding list but who were at heightened risk due to their individual characteristics (e.g. age, ethnicity). This need was particularly pressing due to the lack of clear, profession-specific guidance from Governments. The BMA provided this guidance titled *'Covid-19: doctors isolating and those in vulnerable groups'* (Exhibit IK/4).

c. On 10 July 2020 the BMA published a briefing on supporting staff who were shielding to return to work, stating that "national guidance [was] limited" around CEV healthcare staff returning to work safely[36]. This was published just as the first period of shielding was drawing to a close in Scotland.

d. Doctors and medical students who were categorised as CEV experienced a range of issues including: disruption to training and career development; isolation from peers; job insecurity; and practical challenges around remote working. These impacts, as well as shielding itself, were likely exacerbated by a lack of

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[36] BMA paper: 'Briefing on supporting staff who are shielding to return to work' (July 2020). Available at: https://www.bma.org.uk/media/2854/bma-briefing-on-supporting-return-to-work-july2020.pdf

clear guidance and adversely impacted doctors' emotional wellbeing, with many experiencing guilt, anxiety, loneliness and frustration.

51. Changes to healthcare delivery models which resulted in doctors having to work longer hours and less flexibly impacted those with caring responsibilities.

   a. In the BMA's UK-wide Covid Tracker survey of April 2021 women showed higher levels of stress and burnout, with the survey findings indicating higher than normal levels of exhaustion were more common among women (61%) than men (52%)[37].

   b. The gender discrepancy may have been partly due to additional commitments outside work, such as childcare or other caring responsibilities, a duty still largely borne by women. Some respondents to the Call for Evidence survey also observed the particular impacts on female staff, for example a Consultant in Scotland said "*There has been a significant toll amongst the women Consultants in our Department. It is of note, we all have children of school age and at some point have been in tears after meetings with our Clinical Lead and Management when requesting a bit of flexibility. In a department where we used to pride equality, our opinion is that we were treated differently during the pandemic because we couldn't always toe the line with regards to extra workload owing to childcare.*"

Staff were not sufficiently protected

52. Throughout the pandemic there were significant shortcomings in how staff working in healthcare settings were protected from the virus, spanning inadequate IPC guidance, a lack of adherence to health and safety law, some shortages of PPE – particularly early in the pandemic - and, where PPE was available, a lack of access to well-fitting or appropriate PPE. This impacted all healthcare workers negatively, with certain groups impacted even more due to their individual characteristics (see paragraphs 47 - 51).

Infection Prevention and Control (IPC) guidance and personal protective equipment (PPE)

53. IPC guidance on Covid-19 in healthcare settings, which was intended to keep staff and patients safe, has been inadequate throughout the pandemic, putting both staff and patients at risk. The fact that employers followed this guidance rather than existing health and safety law – and that government and responsible agencies have been unmoved by requests by the BMA and others to make changes to the guidance to

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[37] BMA Covid Tracker survey (UK-wide), 19 April 2021. This question was answered by 5,002 respondents who provided information about their gender. A gender breakdown within Scotland respondents is not available.

improve it - sadly mean these shortcomings, particularly in relation to recommended protective equipment for healthcare workers treating patients with Covid-19, are still not sufficiently resolved to the current day.

54. The focus on 'aerosol generating procedures' (AGPs) (see below) in IPC guidance did not reflect the reality of how Covid-19 was transmitted:

   a. For the majority of the pandemic – except for a brief period in the early weeks of the pandemic and between January and March 2022, the four nation UK IPC guidance for healthcare settings (which was updated regularly) stated that only a small number of AGPs required healthcare staff to have access to respiratory protective equipment (RPE) such as FFP2 or FFP3 respirators (which provide the most protection against an airborne virus) and that Fluid Resistant Surgical Masks (FRSM) (which are not intended to provide protection against infectious aerosols) are appropriate protection for a healthcare worker caring for patients with confirmed or suspected Covid-19.

   b. This categorisation of procedures into AGPs and non-AGPs was developed before the pandemic. AGPs include procedures where there was a defined risk of aerosols being generated because of a procedure, like endotracheal intubation to secure the airway to enable mechanical ventilation. However, in practice this categorisation has not been a reliable method of mitigating the risk of Covid-19 infection, because it is not always possible to distinguish procedures that generate aerosols from those that do not. The BMA also did not consider the category to be sufficiently inclusive, as it excluded cardiopulmonary resuscitation (CPR) (including chest compressions). Further, the distinction in the IPC guidance between AGPs and other activities does not take account of the fact that daily actions such as coughing, talking and breathing can also generate significant levels of aerosols.

55. Assumptions about airborne transmission left staff at risk from a potentially deadly virus:

   a. The understanding of the significance of airborne routes of transmission of Covid-19 evolved over the pandemic. What has been known for a long time though is that RPE, such as FFP3 respirators, provide significantly greater protection for healthcare staff compared to FRSMs for an airborne virus. This was included in a 2008 report prepared for the Health and Safety Executive[38]

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[38] Evaluating the protection afforded by surgical masks against influenza bioaerosols: Gross protection of surgical masks compared to filtering facepiece respirators. A report prepared by the Health and Safety

which found that, where there is a respiratory risk of infection, the use of FFP3 devices represents best practice, and where these are not available then FFP2 may be an acceptable, pragmatic compromise. The report also explains that filtering facepiece respirators are classified as FFP1, FFP2, and FFP3 according to the level of protection they afford, with FFP3 offering the most protection and FFP2 and FFP1 providing correspondingly less protection[39]. The greater protection offered by FFP3 respirators compared with FRSM against Covid-19 was also demonstrated by a research study undertaken during the pandemic[40].

b. The seeming assumption that aerosol transmission only occurs during AGPs and that, outside of these specific procedures, droplet and fomite (surface) transmission was the primary pathway for Covid-19 transmission had profoundly adverse consequences for the IPC guidance.

c. In the Covid-19 tracker survey of February 2021, only 40% of respondents from Scotland felt safely protected by the PPE provided to them in 'non' AGP areas[41]. As described by a Consultant in Scotland: *"There was an emphasis on theatres and ITU, where I could have what I needed, but on the wards it was impossible, which was where there was a higher density of people, simple surgical masks and far worse ventilation/air exchange than elsewhere."*

d. Ensuring staff are provided with the most effective protection is also important to the psychological safety of those being relied upon on the healthcare frontline. This is one of the reasons why, even in the early months of the pandemic when there was a lack of consensus about whether and to what extent Covid-19 was spreading via the airborne route, the BMA argued for a precautionary approach.

e. Assumptions around airborne transmission, particularly early in the pandemic, also had consequences for indoor ventilation and air quality monitoring which

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Laboratory for the Health and Safety Executive (2008). Available at: https://www.hse.gov.uk/research/rrpdf/rr619.pdf

[39] In the 2008 report prepared for the Health and Safety Executive, FFP3 has 99% filter efficiency and an assigned protection factor of 20. FFP2 has 94% filter efficiency and an assigned protection factor of 10. FFP1 has 80% filter efficiency and an assigned protection factor of 4.

[40] Ferris et al. (2021). Efficacy of FFP3 respirators for prevention of SARS-CoV-2 infection in healthcare workers. Elife. Available at: https://elifesciences.org/articles/71131

[41] BMA Covid Tracker survey (UK-wide), 08 February 2021. This question was answered by 895 respondents in Scotland.

are important to mitigate the risks of airborne pathogens. Where adequately prioritised, enhanced ventilation can help mitigate risks to staff and patients. However, many parts of the health service estate found such improvements hard to deliver. In a BMA Covid-19 Tracker survey in April 2021[42] almost 4 in 10 (39%) respondents from Scotland said their place of work did not have sufficient ventilation (Exhibit IK/3), underlining the difficulties that some of the health service estate had and continue to have.

56. The guidance in all four nations continues to state that a FRSM is adequate protection for a healthcare worker undertaking routine care of a Covid-19 positive or suspected positive patient:

   a. In Scotland a new annex 19 was published in May 2023 that states: *"Where staff have concerns, they may choose to wear an FFP3 respirator rather than a fluid resistant surgical mask (FRSM) when providing patient care, provided they are fit tested. This is a personal PPE risk assessment"*[43]. How this interacts with the rest of the guidance is unclear and it further places responsibility on the healthcare worker to raise concerns and ensure they have the necessary fit testing. Moreover, given BMA survey findings at a UK-wide level that ethnic minority doctors and those with a disability or long-term health condition felt less able to raise concerns about PPE[44], this position may exacerbate existing inequalities.

   b. In the BMA's view, the current guidance is inconsistent and confusing. Almost four years after the virus came to the UK's shores it continues to leave healthcare workers unprotected against the continuing risks from Covid-19.

57. BMA Scotland raised concerns about IPC failings throughout the pandemic, including within email communication to the Chief Medical Officer (CMO) for Scotland, the CEO of NHS Scotland, senior leaders in the Health Workforce Directorate and the HCAI/AMR (Healthcare Associated Infections and Antimicrobial Resistance) Policy Unit (see paragraph 167). In primary care specifically, BMA Scotland called for GPs to have consistent access to FFP2/3 respirators when working with patients with suspected or

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[42] BMA Covid Tracker survey (UK-wide), 19 April 2021. This question was answered by 579 respondents in Scotland.

[43] National Infection Prevention and Control Manual, Chapter 2, 15 May 2023. Available at: https://www.nipcm.hps.scot.nhs.uk/chapter-2-transmission-based-precautions-tbps/print

[44] BMA Covid Tracker survey (UK-wide), 14 May 2020. Within respondents in Scotland, a breakdown by ethnicity is not available.

confirmed Covid-19, calling for this in bilateral meetings with Scottish Government Primary Care Directorate as well as with the Health Workforce Directorate via email.

58. These concerns were also raised in BMA Scotland blogs, for example in May 2020 BMA Scotland issued a statement[45] raising concerns about the categorisation of AGPs, including the exclusion of chest compressions from this category (as outlined earlier in paragraph 54), and the need for healthcare staff to be protected by RPE. This was the position of the Resuscitation Council UK, which BMA Scotland supported. Scottish Government guidance at this time did not mandate the use of RPE when performing CPR (because CPR was not classified as an AGP), and many BMA Scotland members raised serious concerns about this lack of higher-level protection. BMA Scotland's attempts to suggest modifications to this guidance were not welcomed or met with a willingness to change the guidance to better protect doctors and other healthcare staff responding to such emergencies. BMA Scotland were concerned at the time, and remain so, that there was not sufficient weight given to the views of staff in these circumstances, or that their safety was properly prioritised.

PPE

59. Delayed procurement, delivery and PPE not fit for purpose meant that medical professionals on the frontline often had to go without PPE, reuse single-use items, use items that were out of date with multiple expiry stickers visibly layered on top of each other, or use homemade or donated items. This was especially true in the Spring of 2020.

60. Like many issues in the Covid-19 pandemic, PPE and its lack of availability did not impact the medical profession equally. At a UK-wide level doctors from ethnic minority backgrounds more commonly experienced shortages and pressure to work in environments without sufficient PPE[46] and ethnic minority doctors and those with a disability or long-term health condition were more likely to report feeling worried or fearful to speak out about a lack of PPE[47]. The BMA repeatedly highlighted that medical professionals were not being provided with the PPE they needed throughout the pandemic, and BMA surveys captured at first hand these acute shortages.

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[45] BMA Scotland blog 'Covid-19 update from BMA Scotland Chair' (14 May 2020), available at: https://bmascotland.home.blog/2020/05/14/covid19-update-from-bma-scotland-chair/

[46] BMA Covid Tracker survey (UK-wide), 30 April 2020. Within respondents in Scotland, a breakdown by ethnicity is not available.

[47] BMA Covid Tracker survey (UK-wide), 14 May 2020. Within respondents in Scotland, a breakdown by ethnicity and disability/long-term health condition is not available.

61. PPE shortages were experienced in both AGP and non-AGP settings:

    a. Early in the pandemic, shortages of PPE were so severe that at the time the BMA had to produce guidance for staff detailing their rights as well as moral obligations if they did not feel adequately protected (Exhibit IK/5). Worryingly, many respondents to the Call for Evidence survey, particularly those working in hospitals, reported feeling pressured to work without adequate protection and described the worry and anxiety this caused. Many described how exposed, poorly protected and incredibly let down they felt, for example a GP in Scotland said *"Uncertainty was the most difficult part I think. Opening packs of PPE delivered to the practice, and seeing a very out of date "use by" date when we peeled off a handwritten new date sticker that was covering it. Did not inspire trust".*

    b. PPE shortages were most acute in the first Covid-19 wave, with 81% of respondents to the Call for Evidence survey from Scotland saying they did not feel fully protected during the first wave[48]. However, protection for healthcare workers was lacking throughout the pandemic.

    c. Respondents to the BMA's April 2020 UK-wide Covid-19 tracker survey working outside of AGP environments, but with patients with possible or confirmed Covid-19, reported shortages of PPE. Amongst respondents from Scotland, almost three in 10 (29%) said they lacked eye protection, over three in 10 (32%) were without scrubs and 14% reported a lack of even basic FRSMs[49].

    d. Shortages were also experienced in settings where AGPs were carried out. By early April 2020, respondents from Scotland who worked in an AGP setting told us that there were still considerable shortages or no supply of full-face visors (66%), disposable goggles (63%) and FFP3 masks (52%)[50].

62. PPE fit and availability of fit testing was a further factor which limited the protection of doctors and particularly impacted certain groups, such as women, ethnic minorities and disabled people:

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[48] BMA Call for Evidence survey (UK-wide), 17 December 2021. This question was answered by 240 respondents in Scotland. Of these, 30% stated that they felt 'not at all protected' and 51% felt 'partly protected'.

[49] BMA Covid Tracker survey (UK wide), 30 April 2020. This question was answered by 765 respondents in Scotland.

[50] BMA Covid Tracker survey (UK wide), 6 April 2020. This question was answered by 69 respondents from Scotland.

a. For PPE, especially RPE such as FFP2/FFP3 respirators, to work effectively they must be properly fitted and be tight fitting. Poor availability of fit testing to ensure properly fitted masks was a frequent problem cited by respondents in the Call for Evidence survey. Moreover, where fit testing did occur, it was often useless as shortages meant only poor-fitting masks were available. As described by a Consultant in Scotland: *"fit testing was poor and the masks that fitted me kept running out."*

b. Women particularly struggled to find well-fitting masks. There is a gender bias within PPE – which is largely manufactured to suit white male faces and physiques – meaning PPE was less likely to fit women, despite making up around 77% of the UK healthcare workforce[51]. This was a problem that emerged at the start of the pandemic and persisted throughout.

c. Similarly, non-BMA research[52] suggests that failure rates for fit testing are higher in staff from ethnic minority backgrounds compared with staff of White ethnicity, and at UK-level the BMA raised the disproportionate impact of PPE decisions on staff from ethnic minority backgrounds and certain religious groups (such as those who wear a beard or hair covering for religious reasons). Access to well-fitting PPE was raised as a problem by some ethnic minority respondents in the Call for Evidence, for example a Black/Black British Consultant in Scotland said *"Using FFP3 with black hair is easier with a hair cover. The elastic snags. PPE posters do not routinely show or normalise the reasonable adjustments necessary for non-religious and religious reasons for covered hair."*

d. In addition to these challenges, the universal need for masks and respirators in clinical settings caused difficulties for Deaf healthcare workers who relied on lipreading for communication. While steps were eventually taken to mitigate such issues, such as the development of clear face masks, progress was painfully slow.

63. The BMA also received testimony in the Call for Evidence survey about the quality of guidance on how to safely use PPE in healthcare settings. Practices like safe donning and doffing play a key role in ensuring the safety of the wearer and ensuring that hazardous PPE is safely disposed of. There was a large degree of variation among

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[51] Chakladar and Ascott (2021). Blog for the British Medical Journal entitled 'Personal protective equipment is sexist'. Available at: https://blogs.bmj.com/bmj/2021/03/09/personal-protective-equipment-is-sexist/

[52] Green et al. (2021). Fit-testing of respiratory protective equipment in the UK during the initial response to the COVID-19 pandemic. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8087583/

respondents in how well trained they were in using PPE, but also in safely removing it. Some respondents reported receiving effective donning and doffing training and they emphasised that this was usually locally organised and in contrast to centrally administered guidance. Others reported receiving little to no training and being expected to instinctively know what procedures to implement.

64. BMA Scotland engaged frequently and at a high level with the Scottish Government in raising the concerns of the BMA's membership, drawing from their experiences of what failing to supply adequate PPE meant to those who desperately needed it. These concerns were raised over many months, spanning March 2020 – April 2022, and with a number of parties within the Scottish Government (see paragraphs 160 - 169).

    a. For example, as early as 14 February 2020 the Chair of BMA Scotland's GP Committee (SGPC) wrote to the CMO to highlight that GP practices *"have been promised PPE masks – however, these have not arrived in many areas which is a delay of several weeks"*. (Exhibit IK/6). In response the SGPC Chair was told to suggest GPs contact their local health board.

    b. In March 2020 the BMA wrote to the Prime Minister highlighting deep concerns about PPE shortages amongst frontline staff and the impact of this inadequate provision on both levels of infections and staff mental health. BMA Scotland shared that correspondence with the Director General for Health and Social Care and the CMO for Scotland to highlight similar ongoing concerns in Scotland (Exhibit IK/7). BMA Scotland then continued to raise these concerns on a regular basis within subsequent meetings and email correspondence.

    c. In January 2021 BMA Scotland raised concerns about the level of protection provided by the recommended PPE and called for the Scottish Government to protect the safety of healthcare staff by reviewing the guidance and providing FFP3 respirators and eye protection in a wider range of situations. The BMA wrote to Public Health England and BMA Scotland shared that correspondence with Health Protection Scotland (Exhibit IK/8) and the Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) programme (Exhibit IK/9) to ensure they were fully aware of the issue. ARHAI replied outlining their process for reviewing the guidance (Exhibit IK/10). At that time concerns about poorly fitting PPE, particularly female doctors still struggling to find well-fitting masks, were also raised with the Scottish Government and assurances sought that these issues were being addressed.

d. In January 2022 – a year later – BMA Scotland continued to raise issues directly with the Scottish Government (Exhibit IK/11). In a blog at the time[53], BMA Scotland Chair Dr Lewis Morrison wrote: *"We have repeatedly asked Scottish Government to review their guidance on PPE and have done so again. It's clear we need to have a system which enables staff in both primary care and secondary care to request the PPE they believe they need after risk assessment without barrier or judgement – the system needs to say "yes" to those requests and not "label" asking for something as unusual or even out of order. This was one of several issues I raised with the Cabinet Secretary Humza Yousaf when we met earlier this week and I am grateful that he agreed to speak again with his clinical advisers about it and we will follow up on this".*

65. BMA Scotland also consistently raised concerns about PPE within media interventions and blog posts[54].

Lack of adherence to health and safety law

66. It is the BMA's view that, during the pandemic, employers were more likely to follow the IPC guidance, rather than their legal obligations under Health and Safety Law. This may be because they believed that the IPC guidance superseded their legal obligations, or they may have not understood the relationship between the guidance and the law. As set out above, the IPC guidance was clearly deficient. However, the risks this posed to staff and patients could have been mitigated if employers had focused on their legal obligations under Health and Safety laws and if the HSE had taken a more proactive approach in ensuring employers were aware of - and complied with - these duties.

67. Health and Safety laws pre-dating the pandemic set out employers' legal duty to protect staff from harm in the workplace, including through conducting individual and workplace risk assessments to identify hazards and ameliorate the impact of them on staff. Importantly, these legal duties were not superseded by IPC guidance for Covid-19 in healthcare settings and IPC or other processes to mitigate hazards should not be seen as divorced from them. As the regulator responsible for the health and safety of UK workers the BMA was surprised that the HSE did not take a more proactive approach in ensuring compliance across healthcare settings with existing health and safety

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[53] BMA Scotland blog: 'The ongoing impact of Covid on doctors: PPE, testing and mental exhaustion' (14 January 2022), available at: https://bmascotland.home.blog/2022/01/14/the-impact-of-omicron-on-doctors-ppe-testing-and-mental-exhaustion/

[54] See for example BMA Scotland blogs: 'Covid-19 – BMA Scotland update' (27 March 2020), available at: https://bmascotland.home.blog/2020/03/27/covid19-bma-scotland-update/ or 'General practice updates for Covid-19' (03 April 2020), available at: https://bmascotland.home.blog/2020/04/03/general-practice-updates-for-covid-19/

legislation, and by engaging with, or challenging as necessary, industry-specific guidance.

68. During the pandemic, the BMA regularly called for proactive risk management in healthcare settings in accordance with health and safety law, including additional support for employers to undertake and implement risk assessments that would take into account not only age, but also other factors such as ethnicity, sex and comorbidities (see paragraph 167b).

69. Alongside deficiencies with risk assessment and other protections in the workplace, many employers also failed to report Covid-19 infections of staff via RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations), despite it being a legal requirement for employers to report instances of workplace acquired Covid-19 infections to the HSE. Reporting is crucial to understanding infections at health service staff level, how infection spreads within healthcare settings and how to better protect staff and patients. It may also assist staff with Long Covid developed as a result of an infection acquired at work, in seeking compensation. However, reporting practices varied throughout the pandemic, and at a UK-level only 3% of respondents to the BMA's Long Covid survey (to which most participants believed they acquired acute Covid-19 at work) said they were aware of their potential occupational exposure to Covid-19 and subsequent illness having been reported using RIDDOR.

Risk assessments

70. An employer in healthcare would, by law, have been expected to undertake risk assessments and review them regularly. However, findings from BMA member surveys showed that risk assessment for individual doctors (to identify any factors which could place a person at increased risk of severe disease if infected by Covid-19) was far from comprehensive and, at the start of the pandemic, inadequate.

71. By May 2020, 69% of respondents in Scotland to a BMA Covid Tracker survey[55] had not been risk assessed in relation to their potential contact with Covid-19. In the Call for Evidence survey, over one in three (36%) of the respondents in Scotland who had had a risk assessment felt their risk assessment was ineffective at protecting them at work[56].

72. Respondents to the Call for Evidence survey also told us about their experiences with risk assessments, many of which were negative. The main reason cited among those

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[55] BMA Covid Tracker survey (UK-wide), 14 May 2020. This question was answered by 891 respondents from Scotland.

[56] BMA Call for Evidence survey (UK-wide), 17 December 2021. This question was answered by 186 respondents from Scotland.

who had negative experiences was that the recommendations made in the risk assessment were not fully implemented. This was often because the nature of doctors' roles, their working environment or staff pressures meant they were not able to work in the way recommended to them by their risk assessment. For example a Consultant in Scotland wrote that "*Individual assessments were carried out but not implemented due to pressure of work.*"

73. Many staff had to self-complete their risk assessments without input from their manager or, importantly, occupational health. At a UK-level almost half of respondents to the BMA's Long Covid survey who had been individually risk assessed, said this was a self-completed assessment (48%), compared with one quarter who said a senior clinical colleague/manager had been involved (26%), versus just 6% whose assessment involved an occupational health specialist. This is likely to be a factor in risk assessments being perceived by some doctors as little more than a 'tick box exercise' without clear outcomes.

74. The pre-pandemic under-resourcing of occupational health services meant that when the pandemic struck, the ability to support healthcare staff, including medical professionals, was limited. Indeed, in a BMA Scotland blog post in May 2020[57] one consultant in occupational medicine described it as being a 'forgotten speciality' pre-pandemic. In this blog post, the consultant described *"for days on end I worked into the late evening responding to anxious queries and undertaking risk assessments"* during Covid-19. The under-resourcing of occupational health services impacted the ability of these services to support risk assessment processes during the pandemic, which will have disproportionately impacted those most at risk to serious illness from Covid-19 infection, for example ethnic minority staff, staff with a disability or long-term health condition, or those categorised as CEV.

75. Ethnic minority doctors experienced particular issues with risk assessments. In the Call for Evidence survey, at a UK-wide level respondents from an ethnic minority background were more likely (48%) to say risk assessments had been mostly or completely ineffective, whereas around one third (35%) of their White colleagues were of this view[58].

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[57] BMA Scotland blog: 'Occupational medicine: the hidden specialty' (20 May 2020), available at: https://bmascotland.home.blog/2020/05/20/occupation-medicine-the-hidden-specialty/

[58] BMA Call for Evidence survey (UK-wide), 17 December 2021. Within respondents in Scotland, a breakdown by ethnicity is not available.

76. ONS data from England[59] suggests that healthcare workers were at significantly increased risk of infection from Covid-19 (six times higher than some other occupations). BMA Scotland is not aware of Scotland-specific data on this. Had more staff had access to a timely and comprehensive risk assessment and had the recommendations within their risk assessments been implemented, it is likely that more would have been protected from infection.

77. Given the importance of the issue of risk assessments to the BMA's members and the wider profession, and in the absence of sufficient guidance from governments, BMA Scotland raised its concerns via email to the Director General of Health and Social Care on 29 April 2020 (Exhibit IK/12) (see paragraph 167b). At a UK-wide level the Chair of the BMA's Medical Academic Staff Committee developed a risk stratification tool in June 2020 as part of his professional academic work (Exhibit IK/13). This tool was made freely available to download via the BMA website and BMA Scotland shared it directly with the Director of Health Workforce on 04 June 2020.

<u>Testing</u>

78. Shortages of Covid-19 testing for patients and healthcare staff at the start of the pandemic impacted on workforce capacity and placed additional strain on the health service. Staff were not able to test all patients with relevant symptoms early in the pandemic, when tests were restricted to patients returning to the UK from certain countries (e.g. China or Italy). This was described by a GP in the Call for Evidence, who said: *"Despite reporting several possible cases to public health, none were tested as didn't meet stringent testing criteria at time. Fairly certain I caught it from a patient, I was also refused testing as only symptoms were fever and tiredness…and told to continue working."*

79. This lack of regular testing will likely have meant that fewer infections were picked up (especially mild or asymptomatic ones), leading to increased viral spread amongst staff and patients. As described by a Consultant in the Call for Evidence: *"Lack of testing was an issue. Having seen many unexpected positive results since widespread testing, there were clearly patients at the start who were treated as negative who weren't."*

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[59] ONS (07 July 2020). 'Covid-19 infections in the community in England: July 2020' (Table 8). Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19infectionsinthecommunityinengland/july2020

80. Regular testing was crucial for protecting staff and patients and is something BMA Scotland called strongly for. In the longer term, more widespread testing is also likely to have reduced staff absence by reducing the spread of the virus.

81. BMA Scotland raised this in an email to the Director General of Health and Social Care and CMO for Scotland on 21 March 2020 (Exhibit IK/7). In a blog in April 2020[60], Dr Lewis Morrison welcomed progress with testing but warned he did *"remain concerned about the consistency and capacity of the system across Scotland"*.

82. At a UK-wide level, the BMA published *'Easing the lockdown – principles and priorities'* in June 2020[61], which set out the BMA's view on how restrictions should be eased in a way that would limit transmission of the virus and therefore protect staff and patients. The paper is clear that restrictions could only be eased once every area of the UK had sufficient capacity to test, track and isolate, and that healthcare staff should be tested regularly.

Staffing

83. As outlined in more detail later in paragraphs 114 – 125, the health service in Scotland entered the pandemic with severe staff shortages and high vacancy rates, a situation which was then exacerbated during the pandemic.

84. These severe staff shortages compromised the safety of doctors and healthcare workers by contributing to deteriorating working conditions. Staff felt overworked, exhausted and as if they had no option but to take on ever increasing workloads. This was described in the Call for Evidence by a GP in Scotland who said: *"Demand far exceeds capacity. Yet we continue to meet that demand with impact on our own lives."*

85. BMA Scotland raised concerns about staff shortages consistently for many years before the pandemic – and continued to highlight this as one of the crucial factors, both in how the NHS coped with and recovered from Covid-19. For example, it was a central part of Chair Dr Lewis Morrison's Christmas message in 2020[62]. Dr Morrison said at that point: *"Staffing levels are either getting worse or simply not keeping up with demand."* He also highlighted the results of a BMA Scotland survey which found that more than a third (36%) of respondents felt medical staffing levels where they worked had deteriorated

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[60] BMA Scotland blog: 'BMA Scotland – Covid-19 update' (15 April 2020), available at: https://bmascotland.home.blog/2020/04/15/bma-scotland-covid19-update/

[61] BMA paper: 'Easing the lockdown – principles and priorities (June 2020). Available at: https://www.bma.org.uk/media/2512/bma-easing-lockdown-principles.pdf

[62] BMA Scotland: 'Stop ignoring NHS warning lights, says BMA Scotland chair' (30 December 2020). Available at: https://www.bma.org.uk/news-and-opinion/stop-ignoring-nhs-warning-lights-says-bma-scotland-chair

over the last 5 years. A further 20% said that, while there had been increases in staffing, this was not keeping up with demand.

<u>Vaccinations</u>

86. At a UK-level, some groups of medical professionals experienced challenges in accessing the first dose of the Covid-19 vaccine. For example in the Call for Evidence survey, junior doctors, GP locums and medical students who were not yet deployed and doctors who work in private practice – and therefore did not get offered the vaccine through their employer – were more likely to report difficulty in accessing their first vaccination. Respondents who were pregnant at the start of the vaccination campaign reported receiving conflicting advice on whether to be vaccinated or not which led to confusion and delays even after the advice changed. This was described by a Consultant in Scotland who said *"Messaging to pregnant and breastfeeding women has been unhelpful and vague".*

87. The BMA in all four nations had concerns about changes to the dose interval of the Pfizer vaccination:

    a. The initial rollout of the vaccination campaign in Scotland began on 08 December 2020, with a phased approach as recommended by the JCVI, which would see the vaccine offered to care home residents, those aged over 80 years old, and health and social care workers in the first instance. This initial rollout involved the Pfizer vaccine which required two doses, with the second to be administered within 21 days of the first.

    b. In a joint statement authorising the deployment of the AstraZeneca/Oxford vaccine on 30 December 2020[63], all four Chief Medical Officers confirmed their agreement with the MHRA and JCVI advice that first doses of vaccines would be prioritised for as many people as possible. Operationally this meant that second doses of both vaccines would be given within twelve weeks rather than within Pfizer's initially advised timescale of 21 days. At this point BMA Scotland's members and many other frontline health and care staff had already received their first dose of the Pfizer vaccine and at the time of their first dose had consented to the 21-day interval.

    c. While BMA Scotland appreciated the broad aim to protect the largest number of individuals and reduce the pressures on the NHS, BMA Scotland's considered

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[63] Gov.uk press release: 'Statement from the UK Chief Medical Officers on the prioritisation of first doses of Covid-19 vaccines' (30 December 2020). Available at: https://www.gov.uk/government/news/statement-from-the-uk-chief-medical-officers-on-the-prioritisation-of-first-doses-of-covid-19-vaccines

stance was this should only be achieved within the licenses and usage specification of the vaccine as it stood at the time. The publicly available data from the Pfizer vaccine trial had covered second doses only up to six weeks; therefore it was unknown at that time whether a longer interval would compromise immunity and was against Pfizer's own recommendation. Crucially, BMA Scotland's members (and other health and care workers) were far more likely to be exposed to and infected with the virus in the course of their daily duties compared to the general population.

d. Member feedback received at the time indicated that the decision had been extremely damaging to morale and wellbeing, and staff confidence in the vaccination regime itself. This impact on morale occurred in the context of staff feeling unprotected and let down as a result of PPE shortages earlier in the pandemic. As described by a Consultant in Scotland: *"I was very angry that shortly after receiving the first dose my appointment for the second shot was cancelled. I felt betrayed."*

e. In Scotland, staff working in care homes were receiving the second Pfizer dose at a three-week interval, yet a doctor seeing patients in care homes was waiting 12-weeks between doses.

f. BMA Scotland's significant concerns were communicated to the CMO and Deputy CMO for Scotland via email on 02 January 2021 (Exhibit IK/14) as well as in a meeting of the Workforce Senior Leadership Group. BMA Scotland also raised this issue through the media – most significantly during early January 2021, when Dr Lewis Morrison, Chair of Council at the time referred to concerns during media interviews and quotes provided to the media[64]. Despite raising these concerns on behalf of the medical profession, the 12-week interval remained in place.

Some doctors in general practice experienced abuse

88. Not only did doctors work in highly pressured environments with increasing workloads for most of the pandemic, while putting their lives on the line, they were also subject to increasing levels of abuse and discrimination.

89. Early in the pandemic a significant amount of care, especially in general practice, moved to online provision to keep patients and staff safe. This was the guidance from

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[64] For example the BBC article: 'Covid in Scotland: Medics concerned over 12-week gap between vaccine doses' (06 January 2021). Available at: https://www.bbc.co.uk/news/uk-scotland-55557208

government bodies and it remained in place throughout much of the pandemic. This was a significant change for patients, and for some an extremely difficult adjustment to make, causing considerable uncertainty and fear. While in the early days of the pandemic there tended to be widespread public support for doctors and healthcare workers (for example the 'Clap for Carers' initiative), frustration grew during the later months and patients often directed this frustration at GP practices and their staff.

90. The government guidance regarding remote consultations continued to remain in place and was a key protection against Covid-19 infection for both patients and staff. However, the UK Government failed to explain to the public why this measure continued to be necessary, and negative messaging inevitably reached audiences over the border. This was coupled with some unhelpful narratives driven by some media and politicians in Scotland – although this was largely confined to early in the pandemic and was more limited and more quickly rectified than in England.

91. In the Call for Evidence survey a GP in Scotland described the psychological impact *"from abuse by the media about GPs being lazy. I am physically exhausted with the workload and haven't stopped in 20 months. Psychologically I am ok but can't work at this rate and with this abuse forever."*

92. Overall this served to damage the reputation of the medical profession with some members of the public. It resulted in medical professionals being subject to unrealistic expectations at a time when pressure on GPs – who were having to look after more and more patients unable to access secondary care where backlogs were mounting – was already significant. In the Call for Evidence survey, a handful of respondents linked increased abuse by patients to this poor government support. For example a GP in Scotland wrote *"This attitude in press and by politicians is doing possibly irreparable damage to the morale of GPs and the respect/attitude patients have for us."*

93. BMA Scotland called publicly for this to stop through blogs, media releases and interactions with politicians. For example, in a blog in August 2021[65], the Deputy Chair of BMA Scotland's GP Committee wrote the: *"constant refrain that GPs surgeries are closed has drip-fed an entirely false narrative that has contributed to the abuse that GPs and their staff are receiving every day."* He went on to add: *"But at some point, this has to stop. GPs have been working throughout the pandemic. There were not enough of us before Covid, and during this time we have spent evenings desperately writing online summaries for patients, delivered vaccinations, worked in out of hours and Covid*

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[65] BMA Scotland blog: 'The "vicious circle" damaging GPs has to stop (26 August 2021), available at: https://bmascotland.home.blog/2021/08/26/the-vicious-circle-damaging-gps-has-to-stop/

centres, dealt with patients with illnesses that secondary care are unable to treat as they are equally overwhelmed, tried to support patients with unprecedented levels of anxiety and depression – all while trying to manage the usual ongoing primary care problems while following complex and ever-changing guidance in premises often manifestly unfit for even basic levels of infection control".

94. BMA Scotland was able to work the Scottish Government and produce a joint statement in October 2021[66], that did help reassure some GPs and clarify the position for the public, MSPs and the media. This joint approach to agreeing key messaging and approach was helpful and demonstrated the willingness of the Scottish Government to work together with BMA Scotland to address an issue of significant concern to doctors.

Redeployment placed additional pressures on staff

95. To support the provision of acute Covid-19 care, large scale programmes of redeployment were initiated across UK healthcare settings. Staff were rapidly moved into high-need services such as emergency departments, intensive and respiratory care. During 2020, over half (52%) of doctors in Scotland were redeployed[67].

96. For many doctors, redeployment was a really stressful, difficult period in their working lives, where annual leave and other forms of respite were cancelled to help keep services going for the long, grinding early months of the pandemic. Many staff were also shifted onto different and more onerous rotas in order to cover gaps brought about by redeployed colleagues or ill and isolating staff. Redeployment placed additional pressures on staff who remained behind in their usual work areas, particularly when redeployment lasted longer than anticipated.

97. These changes had a significant negative impact on the wellbeing and working lives of doctors, both physically and psychologically. Doctors held understandable fears about working in high-risk, high pressure, demanding environments. They were concerned not just about their own health, but also about potential future liabilities in relation to choices made in such environments, where they felt less confident working in a different service or felt they were not given adequate training or supervision. As a consultant from Scotland wrote in the Call for Evidence: *"out of area working was awful-stressful-had no*

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[66] Scottish Government and BMA Scotland: 'Joint statement to General Practices from Cabinet Secretary for Health and Social Care and the British Medical Association' (05 October 2021). Available at: https://www.publications.scot.nhs.uk/files/dc20211005bmasg.pdf

[67] The State of Medical Education and Practice (SoMEP) Barometer survey 2020. Prepared by IFF Research for the General Medical Council. Available at: https://www.gmc-uk.org/-/media/documents/somep-barometer-2020-report_pdf-84743621.pdf

idea what I was doing a lot of the time and no evidence base to back up decisions that I made. The first 5 months were awful."

98. There were also issues with the process for redeploying staff to new care settings to support the Covid-19 response, including a lack of notice of being redeployed, pressure to be redeployed, pressure to agree to different terms and conditions and an administrative burden of repeatedly providing documentation. Like many returners, many redeployed staff had to start their deployment without adequate induction or training. The BMA's Covid Tracker survey in April 2020[68] found that of respondents in Scotland who had been redeployed, 27% had not been provided with an induction into the new role and 31% had not been provided with training related to the new role.

99. Redeployment also had particular impacts on specific groups of staff, including:

    a. **Junior doctors:** Redeployment and a reduction in non-Covid care significantly disrupted the ability of doctors to gain experience in certain training placements necessary for career progression within their speciality. At a UK-wide level GMC data shows that 30% of junior doctors had been redeployed within their specialty and 40% outside of their specialty entirely[69]. Amongst respondents in Scotland from the Covid Tracker survey in April 2021, 34% of doctors in training told us they were unable to gain enough experience in non-urgent and scheduled care to fulfil the competencies required for progression in their career, and 26% said the same about urgent and unscheduled care[70] (Exhibit IK/3). A SAS doctor in Scotland, for example, described how *"trainees have been moved around and away from training roles without a plan for getting relevant competencies. Normal training pathways have been disrupted"*. The BMA highlighted the issue of lost training and delayed progression of junior doctors in its UK-wide *Rest, Recover, Restore* report[71] and called for solutions to remedy this. The BMA's *Weathering the Storm* report[72] called for training to be protected wherever possible, particularly for trainees who have already had

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[68] BMA Covid Tracker survey (UK-wide), 30 April 2020. This question was answered by 278 respondents in Scotland.

[69] The State of Medical Education and Practice (SoMEP) Barometer survey 2020. Prepared by IFF Research for the General Medical Council. Available at: https://www.gmc-uk.org/-/media/documents/somep-barometer-2020-report_pdf-84743621.pdf

[70] BMA Covid Tracker survey (UK-wide), 19 April 2021. This question was answered by 62 respondents in Scotland.

[71] BMA report: 'Rest, recover, restore: Getting UK health services back on track' (March 2021). Available at: https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf

[72] BMA report: 'Weathering the storm: vital actions to minimise pressure on UK health services this winter' (November 2021). Available at: https://www.bma.org.uk/media/4834/bma-weathering-the-storm-report-nov21.pdf

their progression impaired by the impacts of the pandemic. A positive in this respect was agreement around two new potential outcomes in the Annual Review of Competency Progression. These were introduced as 'no fault' outcomes to be used when there were no serious concerns about the trainee, however, their training had been held back by redeployment.

b. **Those more at risk of serious illness from a Covid-19 infection:** The BMA also raised concerns about the risks of redeploying staff who were at greater risk of serious illness from a Covid-19 infection, particularly ethnic minority and older staff, to high-risk roles. In April 2020 the BMA raised these concerns in a letter to the CEO on NHS England, which BMA Scotland shared with the Director General of Health and Social Care (Exhibit IK/12).

c. **General practitioners:** In Scotland most patients with suspected Covid-19 in the community were seen in Covid-19 Assessment Centres that were established in most areas by Health Boards and not in GP practices that were protected for other urgent clinical activity not related to Covid-19. Much of the medical workforce within the Covid-19 Assessment Centres were general practitioners that either extended their working hours or reduced sessions in their GP practice. This had a knock-on reduction in GP practice capacity. BMA Scotland's General Practice Committee raised concerns with Scottish Government in bilateral meetings that the workforce for the Covid-19 Assessment Centres should have come from across the NHS and not just primary care/general practice.

100. While the BMA was supportive of the redeployment programme, the BMA had concerns about the logistical and psychological impacts of redeployment on staff, particularly where reasonable requests were not made and notice not communicated. To support members the BMA worked closely with the MSG (Management Steering Group) on specific joint statements on both senior[73] and junior[74] doctor work arrangements.

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[73] MSG, BMA Scotland and Scottish Government: 'Joint statement on Consultants/SAS doctors working arrangements' (September 2020). Available at: https://www.bma.org.uk/media/3291/bma-joint-statement-on-consultants-and-sas-doctors-working-arrangements-sept-2020.pdf

[74] MSG, BMA Scotland and Scottish Government: 'MSG/BMA joint guidance – junior doctors' (November 2020). Available at: https://www.bma.org.uk/media/3487/bma-msg-joint-junior-doctors-rota-guidance-nov-2020.pdf

Schemes were introduced to increase the number of registered medical practitioners

101. Given the significant staffing challenges the UK's healthcare systems faced when the pandemic hit, the BMA believes it was vital to increase the workforce through the measures that were taken, including recruiting and re-registering retired or non-practising doctors to the workforce, early provisional registration of final year medical students and early full registration of foundation year one doctors. However, these schemes were not without challenges.

102. Recruiting and re-registering retired or non-practising doctors:

   a. In Scotland, returners initially contacted their local health boards to offer their services, and 2,000 former health and social care staff signed up within the first two days of recruitment through the Health and Social Care Covid-19 Accelerated Recruitment Portal, which was created to streamline recruitment and to give a national picture of the skills mix on offer.

   b. The success of the returners programme was limited due to factors including:

      i. Older retired doctors were at an increased risk of serious illness from a Covid-19 infection and as such many were unable (due to risk factors and/or comorbidities) or unwilling (due to concerns about the risk to their health and safety) to return to frontline roles. Some will also have had caring responsibilities which would have limited the type and amount of work they could undertake.

      ii. There was frustration with the speed, complexity and bureaucracy of the process. Some felt that processes for returning were cumbersome, including the requirement to undertake mandatory compliance training that was not essential to ensure patient safety and the use of digital platforms to upload employment documentation (some retired doctors did not have access to the digital tools necessary to do this). The BMA called for changes to the former in its *Weathering the Storm* report[75]. For GPs, the process of returning was especially onerous as they required registration on the performer's list on top of GMC temporary emergency registration. For example in the Call for Evidence survey a retired doctor in Scotland who volunteered to return as a GP wrote that they were *"disappointed in the re-registration process which was over*

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[75] BMA report: 'Weathering the storm: vital actions to minimise pressure on UK health services this winter' (November 2021). Available at: https://www.bma.org.uk/media/4834/bma-weathering-the-storm-report-nov21.pdf

complicated and cumbersome" and withdrew their offer to volunteer as a result.

iii. There were highly localised issues finding suitable roles as it depended on demand for returners in local areas and in individual hospitals. For GP returners, there were also capacity constraints in general practice which meant that there was limited time to onboard and train returners.

c. Ultimately, highly qualified and experienced doctors were not utilised as effectively as they could have been. Had the NHS been better prepared, with existing processes for returning, vetting and matching large numbers of staff to areas of need this would likely have helped ameliorate the impact of historical understaffing to some extent and may have meant more non-Covid care could have continued alongside the response to the acute pandemic.

d. For retired doctors returning to practice, many challenges presented, especially early in the pandemic. These included not only ensuring that their clinical competencies and skills were up to date to ensure safe working, but also the fact that proper inductions were not always offered and training and supervision were sometimes inadequate.

e. In December 2020, the BMA surveyed retired members in all four UK nations to ascertain how many had returned to practice and what their experience had been. The findings (although based on a relatively small sample size) presented a mixed picture in terms of how doctors returning to practice found the process. While some reported they had received adequate training and satisfactory guidance and support (especially from their employer and the GMC), many others reported problems (especially with guidance received from coordinating NHS or public health organisations). While most respondents at a UK-level had received training relevant to their role, less than half (49%) said they had received training for specific adaptation to the role or specialty they had been slotted into and only 52% had received a formal induction. Overall, the responses demonstrated a high degree of variability across settings in how doctors returning to practice were supported.

103. Early provisional registration of final year medical students and early full registration of foundation year one doctors:

a. It is to the credit of medical students that many volunteered immediately to help in any way they could with frontline care at the start of the pandemic. To further maximise the number of doctors working on the frontline to support the Covid-

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19 response, the UK Government granted powers to medical schools to graduate final year medical students early if they had met the competencies required to become a doctor.

b. The GMC subsequently provisionally registered any final year medical students who applied, subject to their medical school confirming that they had graduated and had no fitness to practice considerations. The GMC also accelerated full registration for foundation year one doctors to help combat Covid-19.

c. Throughout the period, the BMA was clear that any medical student's involvement must be based on that individual's own decision and students should not be conscripted without their consent.

d. Medical students experienced a number of issues including:

    i. **Training and supervision:** In the Call for Evidence survey respondents told us that classes, conferences and exams were often cancelled and at times mandatory courses were difficult to access or even unavailable. On 4 June 2020, the BMA published a UK-wide *Statement of expectations: Medical student wellbeing support during Covid-19*[76] which called on universities and NHS employing organisations to undertake specific actions to support medical students whose education was disrupted or who were taking up contracts in the NHS to support the pandemic response. These included providing access to tutors, ensuring clear processes were in place to follow up with vulnerable students virtually, ensuring disabled students were able to continue to access support and adjustments, and communicating information regarding changes to any aspect of a student's medical degree, such as exams or assessments, with notice of four weeks or longer. This was undeniably an incredibly difficult time for students studying medicine. In a blog from October 2020[77] the BMA Scottish Council Member for Medical Students at the time described having to *"adjust to hugely reduced face-to-face teaching in a subject that simply can't be taught purely by video link and are having to prepare for*

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[76] BMA paper: 'BMA statement of expectations: Medical student wellbeing support during Covid-19' (04 June 2020). Available at: https://www.bma.org.uk/media/2559/bma-statement-of-expectations-medical-student-wellbeing-during-covid-19-june-2019.pdf

[77] BMA Scotland blog: 'Medical students – away from home in the midst of a crisis not of their making' (02 October 2020), available at: https://bmascotland.home.blog/2020/10/02/medical-students-away-from-home-in-the-midst-of-a-crisis-not-of-their-making/

OSCEs (Objective Structured Clinical Examination) without normal access to peers or patients, simulated or otherwise". The member also described how *"the mental health epidemic already established by COVID-19, superimposed upon the continuing pandemic, is hitting students hard"*. However, even in light of these challenges, it could be argued that the widespread shift to online learning has revolutionised education and work.

ii.   **Contractual issues:** There was variation in how medical students were being contracted to work in health services with some being offered employment contracts and some being encouraged to volunteer their time. Local contracts with highly variable pay and terms and conditions were being offered. To support students entering the workforce, the BMA developed a UK-wide framework contract for medical students and published guidance on the BMA's website (Exhibit IK/15).

iii. **Acting outside of competence:** The BMA was concerned about medical students being asked to act outside of their competency and the BMA was clear that any student taking up work in the health service early would require additional supervision. The BMA in all four nations also wrote to the Medical Schools Council on 19 March 2020 (Exhibit IK/16) raising concerns about medical students stepping into roles where they may be acting beyond their competency and to request that communication to students about local contracts be halted until the BMA was able to develop a framework contract.

Patients were discharged from hospitals into care homes

104. At the outset of the pandemic, health systems across the UK understandably sought to maximise the capacity of their hospitals to meet newly increased demand, particularly for acute care facilities such as ventilated and ICU beds. However, in so doing, the guidance prioritised the rapid discharge of older patients into care homes without adequate testing for Covid-19. Testing for Covid-19 was not widely available at this stage, meaning there was widespread discharge of many hospital patients without being tested – and into environments with people more at risk of severe outcomes from infection with the virus. The risk was further compounded by the possibility of asymptomatic transmission.

105. In Scotland, there were 3,599 discharges from hospitals into care homes between 01 March and 21 April 2020 but, due to clinical guidance at the time, only 18% were tested

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for Covid-19. In contrast, following the issuing of new guidance, 93% of patients discharged from Scottish hospitals to care homes between 22 April and 31 May 2020 were tested for Covid-19[78].

106. In *Rest, Recover, Restore: Getting UK health services back on track* (March 2021)[79] the BMA called for all UK governments to ensure care plans are in place to enable patients to be discharged safely from hospital without undue delays to free up space in hospitals, including the provision of funding for this. The BMA's report, *Weathering the Storm: Vital actions to minimise pressure on UK health services this winter* (November 2021)[80] argued that all UK governments must ensure social care is properly supported financially, to ensure it is able to provide safe care to those who need it, while also helping to reduce pressure on hospital and GP services, as well as to ensure timely discharge from hospital.

Staff had to work with a lack of guidance on emergency triage

107. No government guidance was issued setting out the criteria and policies for determining which patients would be admitted into intensive care units within hospitals or be treated with specific interventions such as mechanical ventilation, in the event that demand outstripped already limited resources or services were overwhelmed. The BMA considers this lack of emergency triage guidance a key failure.

108. Circumstances in which demand outstrips supply raise serious ethical and professional challenges and give rise to the potential for moral injury among those doctors responsible for making final decisions on care escalation, as well as wider concerns about the potential for discrimination in the application of criteria.

109. Healthcare professionals were asking for this guidance and needed it to be issued urgently to enable them to be properly prepared and supported when making decisions about how to allocate limited resources. A lack of guidance in circumstances of extreme uncertainty created anxiety amongst doctors and other healthcare professionals.

110. Pan-profession guidance was commissioned by the four UK CMOs and a small group, including the Chair of the UK Government's Moral and Ethics Advisory Group (MEAG), were tasked with producing draft guidance. However, by 30 March 2020 the UK

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[78] Public Health Scotland, Discharges from NHS Scotland hospitals to care homes between 1 March and 31 May 2020. Available at: https://publichealthscotland.scot/publications/discharges-from-nhsscotland-hospitals-to-care-homes/discharges-from-nhsscotland-hospitals-to-care-homes-between-1-march-and-31-may-2020/

[79] BMA report: 'Rest, recover, restore: Getting UK health services back on track' (March 2021). Available at: https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf

[80] BMA report: 'Weathering the storm: vital actions to minimise pressure on UK health services this winter' (November 2021). Available at: https://www.bma.org.uk/media/4834/bma-weathering-the-storm-report-nov21.pdf

Government decided not to issue this guidance in order to avoid raising public anxiety unnecessarily as they felt that resources would not be exhausted. Given the severe lack of capacity in the NHS under non-pandemic conditions (see paragraphs 114 - 125 below), as well as the critical role that concerns about NHS capacity played in the UK Government's Covid-19 response, the BMA believed that this was not a realistic assumption and that guidance was needed.

111. As a result of the UK Government's decision not to issue guidance, the BMA then issued its own guidance for the profession[81] alongside a set of Frequently Asked Questions (Exhibits IK/17 and IK/18) (see paragraph 157e), as did a number of other organisations. However, having multiple sets of guidance, instead of a central source, created the risk of different interpretations and a lack of clarity for staff.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) notices

112. While the BMA is not aware of members raising concerns about the blanket issuing of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) notices at the time, the BMA was aware of the issue reasonably early in the pandemic through media reports.

113. In response, BMA Scotland communicated with members on the appropriate use of DNACPR. For example, in a blog and communication to members in April 2020[82], the Chair of BMA Scotland's GP Committee wrote: *"We know that CPR is unlikely to work in cases where patients have a cardiopulmonary arrest due to falling ill with Covid and attempting it would be inappropriate, as it would be futile and will only cause harm and distress. But as in non-pandemic times each patient and care home resident should be assessed according to their individual circumstances. It is not appropriate to make a blanket decision not to attempt CPR because of where someone lives."* BMA Scotland advised GPs with queries on this and other issues on working with care homes to contact their Local Medical Committee for further advice.

C. Key issues and impacts for health services

Chronic underinvestment left healthcare systems lacking resilience

114. The worsening state of the health and care system in Scotland in the years leading up to the Covid-19 pandemic played a major role in the way the system struggled to weather

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[81] BMA paper: 'Covid-19 – ethical issues. A guidance note' (March 2020). Available at: https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf

[82] BMA Scotland blog: 'Covid-19 – update from general practice' (21 April 2020), available at: https://bmascotland.home.blog/2020/04/21/covid19-update-for-general-practice/

the storm when Covid-19 arrived and exacerbated the severe disruption to healthcare delivery. Prior to the pandemic, Scotland's public health and healthcare systems were understaffed and under-resourced, and barely able to cope with pre-Covid levels of demand.

115. In the period prior to the pandemic Scotland's health services experienced chronic underinvestment, a lack of workforce planning, acute staffing shortages, reduced bed stock, unsafe bed occupancy levels, year-round capacity issues, growing waiting lists, neglected infrastructure and deteriorating equipment.

116. These fault lines were brutally exposed by the pandemic. It resulted in unprecedented measures to bring in staff, including calls for retired doctors and nurses to return to service, medical students joining the workforce early and the use of volunteers. Staff had to be redeployed, often starting new roles without training or adequate supervision. Significant staffing shortages impacted on the capacity to treat patients as well as the quality of care provided. Many elective procedures, diagnostic tests and routine outpatient services were suspended so that staff, resources and beds could be utilised for Covid-19 care. The consequences of these pre-pandemic failures are still impacting health services today, with the waiting lists for treatment in Scotland standing at 151,093 for inpatient admissions and 525,654 for outpatient admissions[83].

Staffing and workforce shortages significantly impacted the pandemic response

117. The UK entered the pandemic with significantly lower staffing levels than it should have had, including significant medical workforce shortages. Compared to many other OECD nations, the UK had far fewer doctors per 1,000 people when the pandemic began: the 2019 average in OECD nations was 3.6 doctors per 1,000 population, compared to only 3.0 in the UK[84]. Between 2013 and 2019 the secondary care workforce in Scotland grew at a steady rate[85] however the number of GPs remained relatively flat in terms of both headcount and WTE (whole time equivalent)[86]. During this time the population of

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[83] Public Health Scotland NHS Waiting Times – Stage of Treatment at 30 September 2023. Available at: https://publichealthscotland.scot/publications/nhs-waiting-times-stage-of-treatment/stage-of-treatment-waiting-times-inpatients-day-cases-and-new-outpatients-quarter-ending-30-september-2023/

[84] OECD data of doctors per 1,000 people. Available at: https://data.oecd.org/healthres/doctors.htm

[85] TURAS, NHS Scotland Workforce. Available at https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/07-march-2023-workforce/dashboards/nhs-scotland-workforce/

[86] TURAS, General Practice Workforce Survey 2023. Between 2013 and 2019, GP headcount increased by 0.1% and WTE decreased by 1.7%. Between 2019 and 2023, GP headcount increased by 1.7% and WTE decreased by 3.7%. Available at: https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/general-practice-workforce-survey-2023/annual-report

Scotland increased by 2.5%[87] and both primary and secondary care struggled to meet ever-increasing demand.

118. In Scotland, a health and social care workforce plan was published in December 2019[88], however there was not enough time for the plan to have effect before Covid-19 arrived and the publication of a strategy does not in itself guarantee sustained commitment to, or sufficient investment in, multi-year workforce growth and planning.

119. Not only did the UK have fewer staff than other comparable nations, there were also high vacancy rates for medical posts in March 2020, and high levels of attrition. In March 2020, vacancy rates in Scotland[89] stood at 8.2% for medical posts and 5.6% for nursing posts, both well above the 2.6% average vacancy rate across all sectors of the UK economy[90]. It is also worth noting that vacancy data itself is likely to be an understatement of staffing shortages, as some vacancies which are hard to fill or for which no more funding is available are no longer advertised. FOI requests conducted by BMA Scotland in December 2022 revealed that consultant vacancies are likely twice as high as official rates suggest[91].

120. The pandemic exacerbated pre-existing staffing shortages due to a combination of factors including:

   a. **Staff absences** increased during the pandemic due to sickness, self-isolation and the need for CEV staff to shield, not all of whom were able to work remotely. Staff had already been expected to cover staff absences before the pandemic hit, meaning there was no further slack in the system to cover the increased absence rates as a result of Covid-19. In Scotland, the number of NHS hospital

[87] ONS, Population estimates time series dataset. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatestimeseriesdataset

[88] NHS Scotland 'An integrated health and social care workforce plan for Scotland' (16 December 2019). Available at: https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2019/12/national-health-social-care-integrated-workforce-plan/documents/integrated-health-social-care-workforce-plan-scotland/integrated-health-social-care-workforce-plan-scotland/govscot%3Adocument/integrated-health-social-care-workforce-plan-scotland.pdf

[89] TURAS, NHS Scotland workforce (FTE), December 2019. Available at: https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/03-march-2020-workforce/ Note: Data is for the quarter ending December 2019, as data collection for the quarter ending March 2020 was heavily affected by the Covid-19 pandemic.

[90] ONS, Vacancies and Jobs in the UK, April 2020. Headcount. Based on data from January-March 2020. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/jobsandvacanciesintheuk/april2020#vacancies-for-january-to-march-2020

[91] BMA Scotland: 'Consultant vacancies "more than double" official figures' (20 December 2022). Available at: https://www.bma.org.uk/bma-media-centre/bma-scotland-consultant-vacancies-more-than-double-official-figures

and community staff absences related to Covid-19 was highest between April and June 2020, hitting over 10,000 Covid-19 related absences per day in early April 2020[92]. As already outlined (see paragraphs 53 - 77), the BMA believes that more adequate protection of healthcare workers, for example through proper risk assessment and access to PPE, including Respiratory Protective Equipment, would have resulted in fewer absences due to Covid-19 infection.

b. The workforce was stretched in many places, as staff were **redeployed** to high-need services to help maintain service provision in critical and emergency care. This led to gaps elsewhere in the system, causing backlogs to build up in other areas, particularly in the provision of elective healthcare services (see paragraph 126 - 131).

c. The **vaccination programme** was extremely successful but impacted staff availability, particularly in general practice. In the Call for Evidence survey a GP from Scotland wrote: *"Having to provide staff to go to the Covid vaccination centres has been very challenging"*.

d. The pandemic impacted **international medical recruitment** due to the combined impact of pandemic-related travel restrictions and regulations resulting from the UK leaving the European Union coming into effect. These impacted people's ability to move to the UK, reduced the overall attractiveness of the UK as a destination to be located since it changed the registration processes for doctors with non-UK qualifications and reduced international recruitment into the UK's health and care services. Data from the GMC reveals a sharp reduction in 2021 in international medical graduates (IMGs) from outside the EEA joining the UK workforce[93]. In the BMA's Call for Evidence survey, a consultant from Scotland wrote that they worked at *"a small rural hospital"* where *"all staff groups are supplemented by locum staff"*, and that *"[m]any of our locum staff come from other countries so travel restrictions hit us hard"*. The BMA is also aware of many IMG doctors who were overseas at the time the pandemic began and were unable to return to the UK and to their jobs as a result of travel restrictions.

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[92] Scottish Government, Covid-19 trends in daily data. On 02 and 03 April 2020 the number of NHS staff reporting as absent due to Covid-19 was 10,391 and 10,501 respectively. Available at: https://www.gov.scot/publications/coronavirus-covid-19-trends-in-daily-data/

[93] The State of Medical Education and Practice (SoMEP) Barometer survey 2021. Prepared by IFF Research for the General Medical Council. Available at: https://www.gmc-uk.org/-/media/documents/somep-2021-barometer-report_pdf-88506203.pdf

121. As a result, the unprecedented measures set out earlier in this statement had to be taken to bring additional staff into the healthcare system including calls for retired doctors and nurses to return to service, medical students joining the workforce early, and an increased use of volunteers. Though these measures ensured continuous care provision in certain high-need areas, it created large gaps elsewhere in the system. The BMA identified several issues with the processes through which doctors were deployed or brought into the system, which were often complex and perceived by many doctors as overly bureaucratic (see paragraphs 95 - 103). It is also worth noting that fewer people retired during the pandemic, instead choosing to remain in the service to help the pandemic effort.

122. The negative impact of the pandemic on staffing came through clearly in the BMA's Covid Tracker surveys. Two months into the pandemic, in April 2020, 14% of respondents in Scotland to the BMA's Covid-19 tracker survey said they had experienced pandemic-related staffing shortages *within the last week*.[94]

123. Staffing shortages were also frequently mentioned by members in the Call for Evidence survey, for example a consultant in Scotland wrote that their *"organisation managed only by restricting routine care and diverting resources"* and that *"there was no spare capacity to deal with Covid"*.

124. Low staffing levels impacted on the capacity of health services to treat patients and on the quality of care provided:

   a. In a survey from 30 April 2020[95], over half (55%) of respondents in Scotland said prioritisation of Covid-19 patients was slightly (28%) or significantly (27%) worsening the care available to other patients.

   b. In the BMA's Call for Evidence survey, respondents described being unable to deliver the standard of care they would have liked to, linking this to low staffing levels. For example, a junior doctor in Scotland wrote that their hospital was *"severely understaffed to cope with clinical demand [...] damaging patient care"*.

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[94] BMA Covid Tracker survey (UK-wide), 30 April 2020. This question was answered by 1,208 respondents in Scotland.

[95] BMA Covid Tracker survey (UK-wide), 30 April 2020. This question was answered by 1,179 respondents in Scotland.

c. The BMA raised these concerns in its June 2021 report on moral distress and moral injury[96], which highlighted the impact of resource constraints on the quality of patient care and the substantial rise in doctors feeling moral distress in connection to this during the pandemic (see paragraphs 27 - 28).

125. These staffing pressures contributed to deteriorating working conditions with staff feeling overworked, exhausted and with no option but to take on ever increasing workloads. This further exacerbated the impact of the pandemic on doctors' mental health and wellbeing (see paragraphs 22 - 33). It is important to recognise that the frontline healthcare staff who bore so much of the brunt of the repeated waves of the pandemic are the same staff who are currently dealing with the unprecedented pressures on the NHS today. The promised time for staff to recover which the then Cabinet Secretary for Health proposed after the first wave of Covid-19 has never materialised and in the current situation looks impossible to deliver. The passing of time makes that need to recuperate and recover no less imperative.

Secondary care experienced increased demand and growing waiting lists

126. The fact that UK healthcare services did not have the staff they needed before the pandemic is illustrated by growing waiting lists. In March 2020, the waiting lists for elective care in Scotland stood at 78,744 for inpatient admissions and 256,417 for outpatient admissions. This is an increase of 73% for inpatient admissions and 23% for outpatient admissions since records began in December 2012[97].

127. Chronic understaffing and low bed capacity led to the need to deprioritise non-Covid care during the pandemic, as not enough staffed beds were available to meet Covid as well as non-Covid demands. Later in the pandemic, staff were expected to both look after Covid-19 patients and deliver close to normal levels of non-Covid care. The delivery of care was also impacted by IPC measures which – while crucially important – reduced throughput.

128. This meant that elective waiting lists and waiting times for outpatient appointments – which had been rising before the pandemic – rose even more significantly. This caused significant issues for general practice in particular (see paragraph 131), which has found

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[96] BMA report: 'Moral distress and moral injury: recognising and tackling it for UK doctors' (June 2021). Available at: https://www.bma.org.uk/media/4209/bma-moral-distress-injury-survey-report-june-2021.pdf

[97] Public Health Scotland NHS Waiting Times – Stage of Treatment. Ongoing waits on 31 December 2012 (45,531 for inpatient and 209,102 for outpatient admissions) and 31 March 2020 (78,744 for inpatient and 256,417 for outpatient admissions). Table 2.2 and Table 1.1. Available at: https://publichealthscotland.scot/publications/nhs-waiting-times-stage-of-treatment/stage-of-treatment-waiting-times-inpatients-day-cases-and-new-outpatients-quarter-ending-30-september-2023/

itself managing patients awaiting secondary care beyond the capacity they are resourced for by some way.

129. While the pandemic increased demand from Covid patients, a wider implication of the pandemic on the treatment of non-Covid conditions was a reluctance on the part of some patients to present at Emergency Departments and urgent care facilities due to fear of the virus, despite having symptoms of major ill-health. In May 2020, the BMA strongly emphasised the need for patients to be encouraged to continue to seek urgent and emergency care if they needed it, and not to be deterred by fear of Covid-19 or of 'burdening' the NHS[98].

130. There was a conscious effort made during the pandemic to prioritise the protection and restoration of cancer care services.

    a. Scotland saw an early decline in the number of cancer patients receiving treatment, before a gradual return to more typical demand. While 6,460 patients received their first treatment for cancer following a decision to treat in the quarter ending March 2020, this dropped to 5,054 and then 4,969 in the following two quarters, before gradually returning to pre-pandemic levels by mid-2021. Notably, performance against the '31-day standard for first treatment following decision to treat' remained above the 95% target during this period – indicating that demand fluctuated more than performance.

    b. The knock-on impact of the pandemic on cancer treatment in the longer term can be seen today, with waiting lists for cancer treatment rising and performance targets being missed. In Scotland, performance against the '62-day standard for first treatment following urgent referral' continues to worsen: in the quarter ending December 2022, only 72% of eligible people received treatment within this target, compared to 84% in December 2019. In contrast, performance against the '31-day standard for first treatment following decision to treat' remains fairly strong and, as of December 2022, sat at around 94%, just below the 95% target[99].

    c. Critically, this fall in activity and subsequent backlog has impacted both diagnosis and treatment – meaning that not only have fewer patients received cancer care, but many patients have also sought or received diagnoses later than would have

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[98] BMA report: 'In the balance: Ten principles for how the NHS should approach restarting non-Covid care' (May2020). Available at: https://www.bma.org.uk/media/2487/ten-principles.pdf

[99] Public Health Scotland cancer waiting times. Available at: https://publichealthscotland.scot/publications/show-all-releases?id=20467

otherwise been the case. Equally, as mentioned above some people avoided healthcare settings as they were worried about Covid-19 infections which may have delayed them seeking care and a potential diagnosis. As these people have sought care this has further impacted the waiting list. Consequently, the impact of the pandemic on cancer services will continue to be felt for years.

Demand in primary care was, and remains, consistently high

131. The pandemic saw increased demand in primary care:

    a. Demand on general practice – which was understaffed and under-resourced even before the pandemic – increased throughout the pandemic and remains persistently high. The deprioritisation of non-Covid care within secondary care services added to the backlog of unmet need in communities, with many secondary care services unable to accept referrals due to capacity constraints and many people waiting months or longer to access treatment. This demand for care has not disappeared but has instead been 'held' by general practice who have been managing and caring for these patients in the interim as they waited for more definitive treatment.

    b. As described by a GP Locum from Scotland when responding to the Call for Evidence: *"There has been little support for primary care to cope with the increase in workload/backlog of patients having not consulted about serious health problems at the height of the pandemic"*.

    c. The Scottish Government established community-based Covid Assessment Centres on 23 March 2020, which aimed to control transmission by separating Covid-positive patients from non-Covid patients. Staff working at these centres came from a variety of services, but a large proportion were staffed by GP practices. While important for infection control, this increased the need for staff cover within general practice.

    d. GP practices were asked by Scottish Government to help identify and proactively manage patients who were at particularly high risk of severe morbidity and mortality from Covid-19. The key asks of general practice included identifying patients in the highest risk groups, providing their Community Health Index (CHI) number to local Health Board team, adding a code to the patient record, sending CMO advice letters to any additional patients identified by the GP practices who had not been centrally identified for shielding, and contacting patients who were sent a shielding letter to discuss their situation.

132. The shift to remote working, particularly in general practice took place rapidly.

    a. Prior to the pandemic around 84% of GP appointments in Scotland were face-to-face, with the remaining 16% taking place virtually. During the pandemic this rapidly shifted to an average of 57% face-to-face and 43% virtually[100].

    b. This change was advised by Governments and was considered essential to stop the spread of Covid-19 while also helping to maximise a limited workforce and allowing staff who had to isolate to work remotely if well enough. GPs continued to provide face-to-face appointments when clinically necessary, and maintained a focus on older patients, shielding patients and patients with poor mental health.

    c. However, the rapid switch to remote consultations also highlighted the limitations of the IT infrastructure across the UK's health services. In response to a BMA survey in May 2020[101], when asked about limitations on their ability to provide remote consultations for patients during the pandemic, 61% of primary care respondents in Scotland reported being limited by IT hardware, 56% by telecoms infrastructure, 52% by internet speed or bandwidth, 50% by mobile devices/apps and 44% by IT software.

    d. The proportion of face-to-face appointments has steadily increased since the height of the pandemic, and as of October 2023 sat at 73% face-to-face and 27% virtual[102].

133. General practice experienced greater autonomy and reduced bureaucracy.

    a. During the pandemic GPs experienced greater autonomy, flexibility and freedom to act in the best interests of their patients, with a reduction in many of the regulatory and contractual requirements that had previously been placed on them.

    b. In Scotland funds were allocated to GP practices early in the pandemic covering costs associated with infection control, staff absences, and additional clinical

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[100] Public Health Scotland, Primary care in-hours General Practice activity visualisation. Averages between 01 March 2020 and 01 June 2022. Available at: https://www.publichealthscotland.scot/publications/primary-care-in-hours-general-practice-activity-visualisation/primary-care-in-hours-general-practice-activity-visualisation-as-at-31-october-2023/dashboard/

[101] BMA Covid Tracker survey (UK-wide), 28 May 2020. This question was answered by 275 respondents in Scotland.

[102] Public Health Scotland, Primary care in-hours General Practice activity visualisation. Available at: https://www.publichealthscotland.scot/publications/primary-care-in-hours-general-practice-activity-visualisation/primary-care-in-hours-general-practice-activity-visualisation-as-at-31-october-2023/dashboard/

sessions – which was extremely helpful. Equally important was the decision to amend the Statement of Financial Entitlements for general practice to include locum cover for sickness absence from the first day of absence and at an improved rate.

c. It is important to capitalise on this greater autonomy and incorporate the positive learning into new ways of working. Whilst some form of oversight and regulation is necessary within any health system this should be light-touch, facilitative and supportive, not constrictive. Reducing the burden on general practice is essential if GPs are to continue to provide safe, high-quality care, to their patients.

Unsuitable physical and digital infrastructure impacted care during the pandemic

134. Many hospital buildings and GP practice premises in Scotland were already unfit for purpose before March 2020. In large part, this was due to the fact that capital investment in the UK's health services had been consistently low in the decade preceding the pandemic. Insufficient capital investment meant that healthcare providers frequently lacked the funds necessary to make improvements or even remedial repairs and upgrades to their estate. It also affected the quantity and quality of available IT and other equipment e.g. ventilators and infrastructure.

135. When the pandemic began, the quality of health services' estates and IT systems significantly reduced their capacity to manage an outbreak of an infectious respiratory disease of the type and scale of Covid-19.

136. Many buildings were unsuitable for full implementation of infection control policies and small spaces made social distancing challenging. Moreover, poorly ventilated buildings posed a huge issue for infection prevention and control, especially for a virus that spreads via the air. As described by a GP in Scotland in the BMA's Call for Evidence: *"inadequate premises and unable to implement basic principals (sic) of IPC."*

137. The state of IT infrastructure (and often connectivity) also hampered staff ability to provide remote consultations where they were needed to keep patients and staff safe.

Mental health services are struggling to cope with demand

138. The pandemic significantly impacted the population's mental health and wellbeing. In March 2022, one-third of UK adults reported that their mental health had deteriorated because of the pandemic. This includes people with pre-existing mental illness, over eight in 10 (81%) of whom reported that their mental health had deteriorated since the

start of the pandemic[103]. In Scotland, average levels of mental wellbeing decreased between 2019 and 2021, and then decreased even further between 2021 and 2022[104].

139. This is especially concerning as mental health services struggle to cope with existing demand, let alone additional demand. This put pressure on other services, especially general practice, meaning their service was stretched even further. While not everyone whose mental health has been impacted by the pandemic will seek or need treatment, many will, and mental health services across the UK are ill-equipped to meet this need. The latest data in Scotland shows that psychological therapies received over 42,000 referrals between July and September 2023 and that one in five people referred currently has to wait more than 18 weeks for treatment[105].

140. The true extent of the damage done by the pandemic to the population's mental health remains to be seen, as this type of impact can manifest over a long time. It is likely most people will only have experienced a short, transitory shock to their mental health. But for others, the impact will be long-lasting. Such deeper, long-term mental health effects will likely be linked to inequalities. Ongoing research, monitoring, and support will therefore be crucial in the years ahead.

141. For example, in a BMA Scotland blog in March 2021[106] a psychiatrist working in child & adolescent services warned of a mental health pandemic that was yet to peak. The psychiatrist described how more people were struggling, saying: *"the negative impacts of social isolation on mental health are well known and children need the social interaction and stimulation of school and activities. I really worry about our more vulnerable families living in poverty, poor housing and lacking accessible, safe outdoor space. We know that the mental health of adults has suffered throughout the pandemic and this inevitably has a huge impact on their children. Our colleagues in Social Work tell us they are equally busy dealing with concerns relating to parental depression, anxiety and alcohol misuse"*. The psychiatrist added: *"I fear in CAMHS [Child & Adolescent Mental Health Services] we may not be passed our peak and could be*

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[103] Royal College of Psychiatrists. 'One third of UK public says their mental health has deteriorated as a result of the pandemic' (22 March 2022). Available at: https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/03/22/one-third-of-uk-public-says-their-mental-health-has-deteriorated-as-a-result-of-the-pandemic

[104] Scottish Health Survey 2022. Available at: https://www.gov.scot/publications/scottish-health-survey-2022-volume-1-main-report/pages/5/

[105] Public Health Scotland, Psychological therapies waiting times, September 2023. Available at: https://www.publichealthscotland.scot/publications/psychological-therapies-waiting-times/psychological-therapies-waiting-times-quarter-ending-september-2023/

[106] BMA Scotland blog: 'The pandemic that has yet to peak?' (04 March 2021), available at: https://bmascotland.home.blog/2021/03/04/the-pandemic-that-has-yet-to-peak/

seeing the impact of this pandemic for years to come…We know how to treat poor mental health in childhood in order to avoid issues persisting into adulthood. We just need to be resourced so we can do this for every child and young person who needs it."

The pandemic profoundly impacted population health and health inequalities

142. The UK's pre-existing health inequalities profoundly impacted outcomes for certain groups in the population. Those who were most at risk of infection, severe symptoms and death were those with the worst health outcomes before the pandemic. Had inequalities been addressed before March 2020, the impact of Covid-19 in the UK is likely to have been less severe.

143. Disabled people were one of the most affected groups. Between March 2020 and January 2021, people with disabilities made up nearly two-thirds (58%) of deaths from Covid-19 in Scotland, despite only 18% of the population having a disability[107]. In relation to ethnicity, during the first wave the risk of death from Covid-19 was twice as likely for South Asian people in Scotland compared to White people[108]. Many people experienced intersectional inequalities, for example through being economically vulnerable, more likely to live in poor quality of overcrowded housing, or through employment in sectors that may increase the risk of exposure to an infectious agent.

144. Those without an official immigration status also faced additional barriers to accessing healthcare. Covid-19 was included on the list of conditions exempt from charges for those not ordinarily resident in the UK, which was a welcome move in trying to ensure that everyone, regardless of their immigration status, felt safe coming forward for timely screening and treatment. However, this did not mean all migrants sought the care they needed, even when entitled to it. Wider charging regimes for 'oversees visitors' accessing non-Covid care remained in place in all four nations.

145. However in some areas, for example access to abortion, the pandemic improved access to healthcare for some groups. The introduction of telemedical abortion in Scotland removed an important barrier to access by allowing women to be counselled and receive pills for early medical abortion without attending a hospital. These changes to early telemedical abortion have been extended in Scotland since May 2022.

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[107] National Records of Scotland, March 2021. Available at:
https://www.nrscotland.gov.uk/files/statistics/covid19/covid-deaths-21-report-week-11.pdf

[108] National Records of Scotland, June 2020. Available at:
https://www.nrscotland.gov.uk/files/statistics/covid19/ethnicity-deceased-covid-19-june20.pdf

146. In March 2021 the BMA published the UK-wide report *'Mitigating the impact of Covid-19 on health inequalities'*[109], which set out the emerging evidence about the impact of the pandemic on certain groups and made recommendations to mitigate these impacts and prevent widening inequalities. The report set out five key priorities: reducing overall transmission of the virus; ensuring vaccine access for groups most vulnerable to the virus; improving financial security to ameliorate the impact of the pandemic on those already on low incomes; protecting the long-term (health) outcomes of children living in deprivation, which were particularly impacted as a result of the pandemic; and investing in a strong public mental health response.

147. The end of free Covid-19 testing in Scotland on 18 April 2022 and the end of the Scottish Government's Covid Highest Risk List (previously 'the shielding list') on 31 May 2022 may have left those categorised as CEV feeling worried and confused. While the decision to end the Covid Highest Risk List was largely due to the protection offered by widespread vaccination coverage, there are also some people such as those taking immunosuppressants who remain at higher risk of infection and hospitalisation from Covid-19 after vaccination, relative to the wider vaccinated population[110] and there is no doubt these changes will have left them feeling isolated and confused.

148. The impact that government actions have on physical and mental health must be central to all government decision-making, following a 'health in all policies' approach. This approach, combined with cross-government strategies to improve population health and reduce health inequalities would reduce the disproportionate impact of future pandemics on certain groups. Action must also be taken to tackle institutional racism within the NHS and reduce levels of mistrust and hesitancy amongst ethnic minority communities when engaging with health services.

D. Overview of work done by the BMA to support doctors in Scotland during the pandemic

149. As outlined in paragraph 15, BMA Scotland aims to support its members to provide the best possible care for their patients. During the pandemic this included: research and surveys to understand the issues impacting doctors across Scotland; guidance on a

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[109] BMA report: 'Mitigating the impact of Covid-19 on health inequalities' (March 2021). Available at: https://www.bma.org.uk/media/3944/bma-mitigating-the-impact-of-covid-19-on-health-inequalities-report-march-2021.pdf

[110] Shen et al. (2022). 'Efficacy of COVID-19 vaccines in patients taking immunosuppressants', Annals of the Rheumatic Diseases. Available at: https://doi.org/10.1136/annrheumdis-2021-222045

number of issues affecting patients, healthcare workers and the delivery of healthcare; reports, papers and briefings; and support services for members.

Research and surveys

150. At a UK-level the BMA undertook regular research surveys with its members throughout the pandemic to help us to understand the different experiences of doctors working on the front line of Covid-19. These surveys included demographic questions to support detailed analysis, which was especially important in the early stages of the pandemic when less was known about the virus. The BMA did not have a formal process for sharing the survey findings with the Scottish Government, but these were shared on occasion (for example on 07 April 2020 and 31 May 2020 (Exhibits IK/19 and IK/20) – see paragraph 167f). Primarily, the surveys formed a key plank of the evidence gathering that was used to understand the experience of doctors on the front line. Eight Covid Tracker surveys were sent to BMA members in Scotland. These surveys took place on: 06 April 2020; 16 April 2020; 30 April 2020; 14 May 2020; 28 May 2020; 18 June 2020; 08 February 2021 and 19 April 2021. Each survey received between 189 and 1,351 responses from doctors in Scotland.

151. In December 2020 the BMA surveyed retired members in all UK nations to ascertain how many had returned to practice and what their experience had been. The survey received 93 responses from doctors across the UK. Due to sample size survey data cannot be broken down by nation.

152. In addition, the BMA undertook surveys of its members, including those in Scotland, during the initial vaccine rollout between January and April 2021, which allowed the BMA to monitor doctors' access to first and second vaccine doses.

153. In March 2021 the BMA surveyed doctors throughout the UK on the issues of moral distress and moral injury. The aim of the survey was to get insight into general awareness and prevalence of moral distress and moral injury among doctors. The survey also tried to gather an understanding of what the biggest contributors to moral distress are and if there are any clear ways to alleviate moral distress and moral injury. The survey received 116 responses from doctors in Scotland.

154. The BMA also conducted its own lessons learned exercise, the "BMA COVID-19 Review" in consultation with its members. The views, findings and recommendations of the BMA and its members are set out within five published reports (see paragraph 158). To inform the BMA COVID-19 Review, the BMA conducted an additional and wide-ranging call for evidence from members, encouraging them to pause and reflect on their experience during the pandemic and providing them with an opportunity to describe the

impact of Covid-19 in their own words. The Call for Evidence survey was held online between 10 November and 17 December 2021 and received 2,484 responses from across the profession with 297 responses from Scotland (the questions are exhibited at Exhibit IK/1).

155. In December 2022 the BMA conducted its Long Covid survey in partnership with the support group Long Covid Doctors for Action. This survey was the first comprehensive survey of doctors with post-acute Covid health complications and was designed to address the lack of systematic review on the long-term effects of Covid-19. The survey was UK-wide and received 603 responses.

Guidance for the profession and the public

156. As noted earlier in this statement, in the absence of clear and adequate guidance on a number of issues affecting patients, healthcare workers and the delivery of healthcare during the pandemic, the BMA published its own guidance on many of these topics.

157. The guidance and advice produced by the BMA includes in relation to:

    a. **Inadequate PPE:**

        i.   In the context of severe PPE shortages, the BMA produced guidance for staff detailing their rights as well as moral obligations if they did not feel adequately protected (published in January 2020) (Exhibit IK/5).

    b. **Risk assessments**:

        i.   BMA guidance on risk assessments for general practice (published in June 2020 and later updated in 2022) (Exhibit IK/21).

        ii. A risk stratification tool for members, which had been developed by the Chair of the BMA's Medical Academic Staff Committee as part of his professional academic work and made freely available to download via the BMA website (published in July 2020) (Exhibit IK/13).

    c. **Redeployment and early registration**:

        i.   BMA guidance for doctors being redeployed, covering issues including giving consent to being redeployed, training, terms and conditions, raising concerns and staff wellbeing (published in April 2020) (Exhibit IK/22).

        ii. BMA guidance for medical students taking on contracts of employment in the NHS (published in April 2020) (Exhibit IK/15).

    d. **Supporting shielding staff:**

i. BMA briefing on supporting staff who were shielding to return to work (published in July 2020)[111].

ii. BMA guidance for doctors isolating and those in vulnerable groups (published in July 2020) (Exhibit IK/4).

e. **Ethical guidance:**

i. BMA ethical guidance on decision making, triage and resource allocation in the event that resources became overwhelmed (published in March 2020 and updated in January 2022)[112]. More information in paragraphs 107 - 111.

ii. A set of FAQs to accompany the above ethical guidance (published in March 2020) (Exhibits IK/17 and IK/18).

f. **Remote consultations:**

i. BMA guidance on video consultations and homeworking during the pandemic (published in March 2020) (Exhibit IK/23).

g. **Staff wellbeing:**

i. BMA poster for staff on supporting the wellbeing of colleagues and themselves (published in April 2020) (Exhibit IK/24).

h. **Reducing transmission of Covid-19:**

i. Guidance for the public on safe tourism during the pandemic (published in June 2020)[113].

ii. Reducing infection risk in healthcare settings (published in November 2020 and updated in August 2021)[114].

iii. Poster on visiting GP surgeries safely (published in July 2021) (Exhibit IK/25).

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[111] BMA paper: 'Briefing on supporting staff who are shielding to return to work' (July 2020). Available at: https://www.bma.org.uk/media/2854/bma-briefing-on-supporting-return-to-work-july2020.pdf

[112] BMA paper: 'Covid-19 – ethical issues. A guidance note' (March 2020). Available at: https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf

[113] BMA paper: 'Tourism in the time of Covid: Outline of the issues and basic principles' (June 2020). Available at: https://www.bma.org.uk/media/2708/20200233-tourism-summary-and-principles.pdf

[114] BMA paper: 'Reducing infection risk in healthcare settings' (August 2021). Available at: https://www.bma.org.uk/media/4376/bma-covid-19-reducing-infection-risk-to-staff-in-healthcare-settings-august-2021.pdf

Reports, papers and briefings

158. The BMA and BMA Scotland produced a number of reports, papers and briefings relevant to the pandemic response in Scotland. These include:

Document	Date	Available at
In the balance: Ten principles for how the NHS should approach restarting non-Covid care	May 2020	https://www.bma.org.uk/media/2487/ten-principles.pdf
The mental health and wellbeing of the medical workforce – now and beyond Covid-19	May 2020	https://www.bma.org.uk/media/2475/bma-covid-19-and-nhs-staff-mental-health-wellbeing-report-may-2020.pdf
Evidence to the Health and Sport Committee Inquiry on resilience and emergency planning	June 2020	Exhibit IK/2
Easing the lockdown – principles and priorities	June 2020	https://www.bma.org.uk/media/2512/bma-easing-lockdown-principles.pdf
Taking a cautious approach to easing restrictions: Measures to support near-elimination of COVID-19 from the UK	February 2021	https://www.bma.org.uk/media/3825/bma-taking-a-cautious-approach-to-easing-restrictions-feb-2021.pdf
Mitigating the impact of Covid-19 on health inequalities	March 2021	https://www.bma.org.uk/media/3944/bma-mitigating-the-impact-of-covid-19-on-health-inequalities-report-march-2021.pdf
Rest, Recover, Restore: Getting UK health services back on track	March 2021	https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf
BMA Scotland brief – Scottish Government debate: Health Recovery	June 2021	https://www.bma.org.uk/media/4748/bma-scotland-briefing-on-health-recovery-jun2021.pdf
Moral distress and moral injury: Recognising and tackling it for UK doctors	June 2021	https://www.bma.org.uk/media/4209/bma-moral-distress-injury-survey-report-june-2021.pdf
Supporting Junior Doctor wellbeing – now and for the future	October 2021	https://www.bma.org.uk/media/4670/bma-supporting-junior-doctor-wellbeing_final-publication-october-2021.pdf
Weathering the Storm: Vital actions to minimise pressure on UK health services this winter	November 2021	https://www.bma.org.uk/media/4834/bma-weathering-the-storm-report-nov21.pdf
BMA Covid Review Report 1: How well protected was the medical profession from Covid-19?	May 2022	https://www.bma.org.uk/media/5644/bma-covid-review-1st-report-19-may-2022.pdf
BMA Covid Review Report 2: The impact of the pandemic on the medical profession	May 2022	https://www.bma.org.uk/media/5645/bma-covid-review-2nd-report-19-may-2022.pdf

BMA Covid Review Report 3: Delivery of healthcare during the pandemic	June 2022	https://www.bma.org.uk/media/5816/bma-covid-review-report-3-june-2022.pdf
BMA Covid Review Report 4: The public health response by UK governments to Covid-19	July 2022	https://www.bma.org.uk/media/5980/bma-covid-review-report-4-28-july-2022.pdf
BMA Covid Review Report 5: The impact of the pandemic on population health	July 2022	https://www.bma.org.uk/media/5981/bma-covid-review-report-5_28-july-2022.pdf
Addressing the health challenge of Long Covid	August 2022	https://www.bma.org.uk/media/6051/20220333-addressing-the-health-challenge-of-long-covid-final.pdf
Building the Future 1: Brick by Brick: the case for urgent investment in safe, modern, and sustainable healthcare estates	December 2022	https://www.bma.org.uk/media/6579/bma-infrastructure-1-report-brick-by-brick-estates-dec-2022.pdf
Building the Future 2: Getting IT Right: The case for urgent investment in safe, modern technology and data sharing in the 2 UK's health services	December 2022	https://www.bma.org.uk/media/6578/bma-infrastructure-2-report-getting-it-right-dec-2022.pdf
Over-exposed and under-protected: the long-term impact of Covid-19 on doctors	July 2023	https://www.bma.org.uk/media/7318/bma-long-covid-report040723.pdf

BMA support services

159. The BMA provided a range of support services to support its members during the pandemic. These included:

   a. **Wellbeing services**, with free confidential counselling and peer support available to all doctors and medical students (including non-members). In addition to this the BMA was able to extend its existing telephone/video counselling offering to include the provision of face-to-face counselling to doctors and medical students in the UK over a 12-month period from the end of April 2021.

   b. **'First Point of Contact' (FPC)** service, providing individualised employment support and advice for members. This service continued during the pandemic but with extended opening hours to provide access to this support later into the evening and at weekends.

   c. BMA Scotland provided a care package known as **BMA Care Boxes** to frontline workers. These boxes included essentials to support frontline workers, such as

snacks, socks or shaving foam as well as guidance from the BMA and details about its wellbeing services.

d. The BMA also **lobbied for key changes** to support members. Without the BMA's intervention and the creation of the Coronavirus Life Assurance scheme, staff not part of the NHS pensions scheme – such as students joining the service early - would not have seen any payments to their relatives if they died while treating others.

e. The BMA also made **changes to how it communicated** with members. It doubled the frequency of members' newsletters, ensured regular engagement with them through social media and launched a BMA Covid app to ensure members had faster access to the latest BMA guidance and information.

f. The BMA also continued to provide its **other regular services for members** throughout the relevant period, including advice related to immigration, ethics, equality and diversity, and specialist HR and employment law advice for GP partners.

g. The BMA also supported a range of projects designed to support the health and wellbeing of doctors, medical students and patients during the pandemic through its charitable arm, **BMA Giving**. Through these grants, the BMA supported a wide range of projects, including: support for doctors experiencing financial hardship; initiatives to support mental health and wellbeing; and projects to mitigate the effect of the pandemic on ethnic minority staff.

E. Engagement with the Scottish Government throughout the pandemic

160. BMA Scotland had a good working relationship with the Scottish Government, Cabinet Secretary for Health and senior civil servants throughout the period in question, with regular telephone discussions, scheduled meetings and email exchanges between the BMA Scotland National Director at the time and her team, and relevant officials and civil servants.

161. This included a clear and direct offer from the Cabinet Secretary, Jeane Freeman, to raise immediate problems directly with her office should BMA members become aware of any. This led to occasional meetings between the BMA Scotland Chair of Council and National Director with the Cabinet Secretary for Health, at which BMA Scotland had the opportunity to submit agenda items in advance.

162. BMA Scotland were usually alerted to Scottish Government strategies for responding to the pandemic when they impacted on the medical workforce. BMA Scotland was not routinely consulted or pre-briefed on wider population-based strategies around lockdowns or mask wearing. Given the First Minister and Scottish Government held close to daily briefings, BMA Scotland was able to monitor these and ensure that it kept up to date on all developments as they occurred.

163. The majority of BMA Scotland's engagement with Scottish Government Ministers, senior civil servants and the CMO throughout the specified period were through the established meetings between BMA staff and Government officials set out below. Civil servants took notes and kept action logs; BMA staff did not separately record notes of these meetings.

164. This participation in regular meetings included:

   a. Regular meetings with members of the Directorate for Community Health and Social Care in the Scottish Government. The BMA does not hold minutes of these meetings and, due to staff changes, has not been able to ascertain what was discussed at these meetings.

   b. Daily meetings of the Health Workforce Senior Leadership Group, which was established by the Scottish Government in response to the pandemic. These reduced in frequency to two or three meetings a week between April and August 2020, and then moved to weekly or fortnightly following August 2020. Agenda items included: health and social care workforce capacity, death in service, practical support for staff, PPE guidance and availability, childcare, medical students, changing facilities, workforce planning, workforce gaps during Covid-19, the NHS Louisa Jordan hospital, recruitment, vaccinations, and Covid-19 testing.

   c. Weekly/fortnightly meetings of the Management Steering Group (MSG) between April 2020 and June 2020. The MSG is a joint body formed of the Scottish Government Health Directorate and NHS Scotland Employers, which existed prior to the pandemic. This group facilitated discussion between BMA Scotland and the Scottish Government, and covered matters including working patterns, renumeration, death in service and support for staff.

   d. Joint meetings between the Cabinet Secretary for Health, BMA Scotland and the Royal College of Nursing (RCN) Scotland. Discussions included PPE concerns, interpretation of PPE guidance, modelling for opening the Louisa Jordan hospital, redeployment, and the recovery period from Covid-19.

e. Participation in the Care Home Rapid Action Group. Set up in April 2020, this group was led by the Scottish Government's Directorate for Community Health and Social Care. It discussed issues affecting care homes during the pandemic including Covid-19 testing and infections, PPE, staffing, communications and visiting.

f. Weekly/fortnightly meetings between the Scottish Government Primary Care Directorate and the BMA Scottish GP Committee in 2020 and 2021 on arrangements and policy covering general practice provision that included: community pathways for Covid-19; arrangements to support GP practices during the pandemic; PPE provision; vaccination arrangements; and shielding.

165. Apart from a period early in the pandemic, when weekly calls took place between the Chair of BMA Scotland's GP Committee and the then interim CMO, there was little one-to-one engagement between BMA Scotland and the CMO for Scotland up until August 2021, and only intermittent engagement from then on. Key topics that were discussed when meetings did happen were around NHS recovery and PPE. BMA Scotland also communicated in writing with the CMO for Scotland via letter and email, details of which are included in paragraph 167 below. This lack of regular communication was disappointing for BMA Scotland, as it was felt that this was a useful channel to discuss ways to support the profession that was not pursued. BMA Scotland also felt that the lack of communication may have been influenced by disagreements such as those over changes to the Pfizer vaccine dose interval. BMA Scotland hopes that allowance for such honest disagreement may be made in the future, and that regular communication can continue regardless.

166. On occasion, communications staff from BMA Scotland met with communications staff from the Scottish Government on an informal basis. This provided staff from BMA Scotland with an opportunity to highlight key issues, for example related to PPE, and to be kept informed about timings of upcoming Government announcements and briefings.

167. Key issues on which BMA Scotland engaged with the Scottish Government include:

a. **PPE:** Raising concerns about PPE shortages, inconsistent interpretations of PPE guidance and the adequacy of protection provided by the recommended PPE. These concerns were raised over many months, spanning March 2020 – April 2022, and with a number of parties within the Scottish Government. These communications included the Cabinet Secretary; the CMO for Scotland; the Chief Nursing Officer Directorate (CNOD); the CEO of NHS Scotland; senior leaders within the Health Workforce Directorate; and the HCAI/AMR (Healthcare

Associated Infections and Antimicrobial Resistance) Policy Unit (Exhibits IK/8 and IK/26 – IK/32).

b. **Risk assessments for healthcare workers**: Calling, via an email to the Director-General for Health and Social Care on 29 April 2020, for a risk profiling framework to be developed to assist employers in conducting risk assessments that take into account factors such as ethnicity, sex and comorbidities, as well as age (Exhibit IK/12).

c. **Ethical guidance:** Calling in April 2020 for improvements to the ethical guidance issued by the CMO for Scotland in order to provide greater clarity and support for frontline workers (Exhibit IK/33).

d. **Shielding communications for patients and GP practices:** Providing input via email into communications drafted by the Scottish Government during April 2020 – July 2020 (for example Exhibits IK/34 and IK/35).

e. **Doctors' appraisals:** Calling, via an email to the CMO for Scotland on 15 January 2021, for appraisal requirements to be suspended again in light of the second wave occurring alongside winter pressures (Exhibit IK/36).

f. **Findings from BMA surveys**: Sharing findings in April 2020 with the Director of Health Workforce and the CMO for Scotland (Exhibit IK/19), and in May 2020 with the Director of Health Workforce, the Cabinet Secretary for Health and the CEO of NHS Scotland (Exhibit IK/20).

g. **Pfizer dosing interval**: Sharing concerns with the CMO and Deputy CMO for Scotland via email on 02 January 2021 (Exhibit IK/14), and in a meeting of the Workforce Senior Leadership Group.

h. **Death in Service benefits:** Calling, in meetings and emails with the Health Workforce directorate during March and April 2020, for the provision of death in service benefits for all doctors and medical students risking their lives in the UK's health services.

168. The guidance produced by the Scottish Government did not always reflect every comment and suggestion from BMA Scotland. However, BMA Scotland generally supported the Scottish Government's actions to control the spread of the virus (for example through the use of Non-Pharmaceutical Interventions (NPIs)), and in particular when the Scottish Government chose to act early and decisively on issues such as mask wearing.

169. Overall, and on issues wider than NPIs, BMA Scotland considers that the degree to which its views, as representatives of the profession, were taken into consideration varied considerably depending on the matters being discussed. Examples of where this did not happen include the decision to increase the interval between the first and second dose of the Pfizer Covid vaccination (see paragraphs 86 - 87) and around issues to do with both the supply and the guidance issued on PPE (see paragraphs 53 - 65). BMA Scotland made a number of representations, mainly by telephone and in the media on both of these issues as set out in this statement. The Scottish Government did go to some lengths to canvass the views of BMA Scotland – in particular early in the pandemic – but did not always act quickly, or indeed at all, on the advice provided. Where they did – such as around the production of the Death in Service Scheme (see paragraph 40) – strong results were achieved that benefited both the profession and the wider NHS.

F. BMA Scotland's recommendations

170. Throughout this witness statement I have highlighted areas where BMA Scotland believes improvements can be made to ensure a future pandemic has less of an impact on doctors and medical students. Broadly speaking BMA Scotland's recommendations fall into four key areas:

  a. **Better resourcing of health, care and public health services** to improve care delivery for patients and reduce pressures on staff both during 'normal' times and during health crises such as pandemics.

      i. There is an urgent need to address the issues of staff shortages, high vacancy rates, unsafe bed occupancy levels and the maintenance and modernisation of estates.

      ii. BMA Scotland consistently warned that staffing, in particular, was too low to safely and effectively meet even pre-pandemic demand. As such, a pandemic would only make staffing pressures substantially worse, for example due to redeployment or the reprioritisation of urgent demands. In future, much more must be done to deliver robust, long term workforce planning and forecasting of staff needed to meet demand.

      iii. This longer-term vision is vital to ensure that the NHS in Scotland is able to go into any future pandemic better prepared, and better staffed, than it was for Covid-19. This includes the effective implementation of the Safe Staffing Legislation passed by the Scottish Parliament, and planning for

and ensuring sufficient surge capacity within the system. As a result of years of underfunding and a lack of strategic planning, the NHS in Scotland struggles to cope with even routine-levels of demand and often operates at, or close to, maximum capacity. When a health emergency hits, there is no spare capacity to respond effectively, forcing difficult decisions to be made and leaving all parts of the health and care system extremely vulnerable.

iv. The logic that an adequately funded, staffed and resourced NHS would be better able to deal with a future pandemic is clear and inescapable, and must be among the primary lessons learned.

b. **Improved protection for all staff and patients across primary, secondary and social care**

i. It is important to ensure that the safety of both those working in and being cared for within health and social care is upheld, with a precautionary approach taken in the event of future pandemics.

ii. There must be urgent action to address the continued risk to staff from Covid-19, including updating the IPC guidance to prioritise safety and the provision of RPE to staff working with Covid-19 patients in all parts of the health and care system.

iii. It is also vital to have: better equipped estates (with adequate ventilation in clinical and non-clinical areas, plus the ability to distance infectious patients from non-infectious patients); a range of PPE suitable for a diverse range of face and body shapes; regular PPE fit testing; sufficient stocks of PPE; agile risk assessments; adequately emphasised health and safety advice; and access to occupational health services.

c. **Greater attention on inequalities and those most vulnerable to a future threat**

i. This includes ensuring that pandemic planning includes full consideration of inequalities, with tangible systems in place to mitigate disparities and detailed plans for how those most vulnerable can be protected quickly.

ii. Likewise, a 'health in all policies' approach and cross-government strategies to improve population health and reduce health inequalities would improve the UK's resilience to future pandemics and thereby help to mitigate some of the impacts on both staff and patients.

d. **Better safeguards for staff**

    i.   This includes plans for the continued delivery of training during the next pandemic, as well as better rotas and T&Cs, including better protections for those putting their lives on the line and their families.

    ii.   There must also be improved support for those experiencing the ongoing effects of the pandemic, including those with Long Covid.

    iii.   For healthcare staff, general wellbeing support – including timely and accessible occupational health assessments and support to access psychological support services – must be made available, with specific support also offered to ensure staff can recover from the pressure of delivering care during a pandemic.

Statement of Truth

I believe that the facts stated in this written statement are true.

Signature:

Personal Data

Name: Dr Iain Kennedy

Date: 01 March 2024